



MHSOAC
Mental Health Services
Oversight and Accountability Commission

Report to the Governor and Legislature

Report prepared by the Mental Health Services Oversight and
Accountability Commission

■■■ January 2012 ■■■

Membership

Chairman

Larry Poaster, Ph.D.

Vice Chairman

Richard Van Horn

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Tina Wooton

MHSOAC Executive Director

Sherri L. Gauger

Vision

Right care, right time, right place for all individuals, children and families at risk for or living with mental illness.



Commission Composition

The Mental Health Services Oversight and Accountability is comprised of sixteen Commissioners that include: the Attorney General or his or her designee, the Superintendent of Public Instruction or his or her designee, the Chairperson of the Senate Health and Human Services Committee or another member of the Senate selected by the President Pro Tempore of the Senate, the Chairperson of the Assembly Health Committee or another member of the Assembly selected by the Speaker of the Assembly and twelve Governor's appointees that represent specific statutory statewide interests.

Mission

Provide the vision and leadership, in collaboration with clients, their family members and underserved communities, to ensure Californians understand mental health is essential to overall health. The MHSOAC holds public mental health systems accountable and provides oversight for eliminating disparities, promoting mental wellness, recovery and resiliency, and ensuring positive outcomes for individuals living with serious mental illness and their families. The Commission recommends policies and strategies to further the vision of transformation and addresses barriers to system change, as well as provides oversight to ensure funds are spent true to the intent and purpose of the Mental Health Services Act.

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Message from the MHSOAC Chair and Vice Chair

Governor Brown and Members of the Legislature:

On behalf of the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) we are pleased to present this report to the Governor and the Legislature. The Mental Health Services Act (MHSA or Act), funded through a one percent tax on personal income in excess of \$1 million, established the MHSOAC to provide oversight and accountability for the MHSA and the larger public community mental health system.

Last year's MHSOAC report highlighted achievements in implementing new public MHSA programs, including those aimed at preventing mental illness from becoming severe and disabling. This year's report addresses the Commission's task to provide meaningful and effective oversight and accountability for the MHSA in a changing mental health environment. With the passage of Assembly Bill 100 (AB 100) in 2011, the Governor and Legislature shifted significant responsibilities for mental health programs from the state to the counties with MHSA funds now going directly to counties without state approval. Additionally, the Governor's proposed Fiscal Year (FY) 12/13 budget eliminates the State Department of Mental Health (DMH).

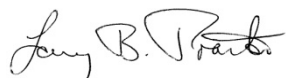
Focused on the administrative system changes described, the MHSOAC has identified oversight and accountability strategies and policy recommendations to support the changing environment. A key strategy is investing in evaluations that demonstrate outcomes from taxpayers' investment in the MHSA. Accountable system improvement requires that these system changes be managed and addressed in ways that will produce the best results for California citizens and inform policymakers.

One of the challenges the Commission foresees is the need to develop policies that provide local flexibility while assuring appropriate state-wide program quality and accountability. The Commission acknowledges that there are many factors to be considered and looks forward to continuing discussion with counties, the Department of Health Care Services and other state entities to develop policies that will lead to effective accountability for the MHSA.

After six years of MHSA program experience, state and local evaluations document improved outcomes for individuals, mental health systems, and local community partners. In 2012, as a result of current evaluation efforts initiated by the Commission, California will report for the first time on specific county and statewide outcomes. The outcomes to be reported are based on analysis of specifically chosen mental health indicators and will be aligned with the National Outcomes Measurement System (NOMS). Expectations are that continued evaluation will document improved life outcomes for individuals and families living with mental health challenges, positive outcomes for mental health, related systems and community partners, and healthier outcomes for California communities.

With the proposed elimination of DMH, the Commission looks forward to working with state entities and counties to ensure that the values and intended outcomes established by the Act continue to be realized.

Sincerely,



Larry Poaster, Ph.D.
Chair



Richard Van Horn
Vice Chair

EXECUTIVE SUMMARY

- The Mental Health Services Act (MHSA) established the Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) to oversee and ensure accountability for the MHSA and for California's public community mental health system.
- The MHSA (funded through a 1 percent tax on individual income over \$1 million) was intended to:
 - expand across the state the new generation of best-practices, recovery-focused mental health programs that had demonstrated their effectiveness for people with serious mental illness,
 - reduce the long-term negative impact on individuals, families, and state and local budgets resulting from untreated mental illness
 - prevent mental illness from becoming severe and disabling.
- Prior to passage of the MHSA, California implemented mental health pilot/demonstration programs intended to help people with serious mental illness recover and lead positive, productive lives. The demonstration programs resulted in powerful positive life outcomes for the individuals served. Evaluations demonstrated the cost-effectiveness of this approach.
- By demonstrating that investment in best-practice mental health programs could make a difference for individuals with serious mental illness and was cost-effective for systems, these demonstration programs provided a foundation for the MHSA. MHSA Full Service Partnership (FSP) programs, were modeled after California's earlier demonstration programs, provide comprehensive services including housing. Continuing evaluations of these programs collect and report individual and system outcomes.
- Although MHSA revenues are volatile, they generate approximately a billion dollars per fiscal year (FY) for California's public community mental health system. Examples of annual MHSA revenues are as follows:
 - \$ 984.3 million - FY 06/07 (actual)
 - \$1,394.9 million - FY 09/10 (actual)
 - \$1,117.3 million - FY 12/13 (projected)
- As State General Funds (SGF) have diminished, MHSA funds have increased significantly as a percentage of total funds available for California's public community mental health system.

What follows are calculations of MHSA funds as a percentage of total funds for California's public community mental health system.

- 11% in FY 06/07 (actual)
- 29% in FY 09/10 (actual)
- 23% in FY 12/13 (projected)

EXECUTIVE SUMMARY (Contd.)

- There have been significant changes over the past year that impact California's public mental health system, the MHSA and the MHSOAC. Specific changes include:
 - MHSA funds go directly to counties without state approval.
 - The scheduled elimination of the State Department of Mental Health (DMH) in FY 12/13.
 - Naming the MHSOAC, in consultation with the state, to establish "a more effective means of ensuring that county performance complies with the MHSA."
- Continuing statutory responsibilities for the Commission include:
 1. Advising the Governor and Legislature regarding actions the state may take to improve care and services for people with mental illness.
 2. Ensuring MHSA funds are expended in the most cost-effective manner and services provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers.
 3. Oversight, review, and evaluation of local and statewide projects and programs supported by MHSA funds.
 4. Ensuring adequate research and evaluation regarding the effectiveness of services being provided and achievement of outcome measures.
 5. Partnering with the state, to establish a more effective means of ensuring that county performance complies with the MHSA.
 6. Providing technical assistance to counties.
 7. Participating in the joint state-county decision making process for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.
 8. Ensuring that the perspective and participation of persons suffering from severe mental illness and their family members are significant factors in all of its decisions and recommendations.
 9. Developing strategies to overcome stigma and discrimination.
- State and administrative system changes must be managed in ways that produce the best results for California citizens, cost-effective results for systems and communities, and critical information for policymakers. The Commission has already begun to advise its government partners and stakeholders on strategies and policy recommendations to be considered in this changing system.
- Because MHSA funds now go to counties without state approval, it is essential there are effective methods for overseeing, reviewing, and reporting county performance. A primary goal for the Commission is to oversee and account for the MHSA in ways that support local flexibility and result in reliable outcome information that documents the impact of the MHSA on California's public community mental health system.
- The Commission's commitment and responsibility to account for the delivery of cost-effective, best practice MHSA services requires strategies for both sound fiscal oversight and evaluation efforts that produce reliable information about individual and system outcomes including the cost and cost benefit of MHSA services.
- As a result of current evaluation efforts initiated by the Commission in 2012, California will report for the first time, on specific, uniform, county and statewide mental health outcomes from all

EXECUTIVE SUMMARY (Contd.)

California counties. This will allow comparison of outcome information county to county, agency to agency, and will provide the basis for the Commission's approach to continuous quality improvement.

- Findings from recent MHSOAC evaluation efforts include:
 1. Activity and expenditure information for local MHSA programs
 2. A study confirming positive MHSA outcomes
 3. Results from a geo-mapping effort that identifies the localized need for and use of mental health services in California
 4. Analysis of the mental health data from the California Health Information Survey (CHIS)
- The Commission intends to build upon past evaluation efforts, utilize what has been learned and expand the scope of future evaluations to address additional areas of focus. MHSOAC evaluation efforts currently underway will produce additional information about the impact of the MHSA on California's public community mental health system. Findings from the current efforts listed below, will be included in next year's Commission report.
 1. An analysis of Full Service Partnership (FSP) program costs and costs per client will be reviewed in the context of FSP outcome information to allow for the comprehensive analysis of the effectiveness of FSP programs.
 2. Review and analysis of first time reports on county and statewide outcomes.
 3. Improvements to the Data Collection Reporting (DCR) system used to collect client-specific outcome information on persons served in MHSA FSP programs.
- In addition to fiscal oversight and specific evaluation activities the Commission supports county performance through the oversight and coordination of training and technical assistance to counties intended to improve the capacity of mental health workers to deliver best practice services.
- MHSA Prevention and Early Intervention (PEI) programs are designed to prevent mental illness and emotional disturbances from becoming severe, disabling and costly to individuals, families, communities and the state. PEI "statewide programs" are intended to have a statewide impact, be implemented more efficiently and effectively and provide a statewide foundation for counties to build upon for long lasting results.

The Commission approved the use of PEI funds for four "statewide programs" focused on:

1. Reducing stigma and discrimination
2. Suicide prevention
3. Student mental health
4. Reducing mental health disparities in access to, use of, and outcomes of mental health services by population groups traditionally underserved

The Commission looks forward to reporting next year about the implementation of various PEI statewide programs.

EXECUTIVE SUMMARY (Contd.)

- Consistent with MHSA values, the MHSA requires the Commission to ensure that the perspective and participation of persons with mental illness and their families is a significant factor in all of its decisions and recommendations. The Commission is involved in multiple activities to increase, sustain and learn from the expertise of persons with lived mental health experience including family members. Some of these efforts include hosting Community Forums throughout California to hear directly from persons about their experiences with mental health services, involving clients and family members in “participatory research”, and conducting a Quality Improvement Survey soliciting input from over 1000 individuals.
- Consistent with its charge to: (1) oversee, review and evaluate state and local projects and programs supported with MHSA funds; and (2) ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of outcome measures, next steps for the Commission include a continued focus on reviewing and analyzing the findings from various evaluation efforts to both inform future evaluations and advise California policymakers about the impact of the MHSA on individuals and systems statewide.
- The Commission will continue to implement Assembly Bill (AB) 100 by collaborating with state entities, counties, and stakeholders to establish a more effective means of ensuring that county performance complies with the MHSA. The Commission will also continue to collaborate and advise on regulations, policies, procedures and other processes that will support meaningful and improved oversight and accountability for California’s public community mental health system in a post-AB 100 environment. Specific tasks for the Commission in 2012 will include working with DMH, the Department of Health Care Services (DHCS), the California Mental Health Directors Association (CMHDA), and stakeholders to review current MHSA regulations to determine which should continue, be revised and/or be repealed. Additionally the Commission will continue its efforts to support strengthening the data infrastructures that provide critical information necessary to perform effective MHSA program evaluations.
- The MHSAOAC has always had statutory responsibility to advise the Governor and Legislature regarding actions the state may take to improve care and services for persons with mental illness. As such the Commission’s focus going forward will include continued advice to and collaboration with the Administration, Legislature, county mental health leadership, other community providers, and mental health stakeholders, about managing the state administrative and system changes in a way that will produce improved life outcomes for individuals and families living with mental health challenges, positive system outcomes for mental health and other community partners, and positive outcomes for California communities.
- The Commission is confident that it can provide the critical information necessary for California citizens and policymakers to assess the impact of the MHSA on California’s public community mental health system. As described in this report, Commission actions and strategies to accomplish this are focused on expanding statewide evaluation of the MHSA and producing reliable information expected to document an improved mental health system in California. With the elimination of DMH, the Commission looks forward to working with state entities, counties and stakeholders to ensure that the values and intended outcomes established by the Act continue to be realized.

INTRODUCTION

This report is organized by the Sections that follow, each describing Commission activities identified as essential to meeting both continuing and emerging Mental Health Services Oversight and Accountability Commission (MHSOAC or Commission) statutory responsibilities.

Oversight and Accountability in a Changing Mental Health Environment

This section describes the Commission's focus on continued advice to and collaboration with the Administration, Legislature, county mental health leadership, other community providers, and mental health stakeholders, about managing state administrative and system changes in a way that will produce "accountable", improved life outcomes for individuals and families living with mental health challenges, positive system outcomes including cost-effectiveness for mental health and other community partners, and positive outcomes for California communities.

Fiscal Oversight

This section describes how the Commission will provide continued fiscal oversight for the Mental Health Services Act (MHSA) and the Mental Health Services Fund (MHSF).

Evaluation

This section describes the Commission's focus on expanded statewide evaluation efforts including review and analysis of county specific performance and outcome reporting.

Oversight, Review, and Evaluation of Local and Statewide MHSA Projects and Programs

This section describes: (1) Commission activities and products that support ongoing county performance including the provision of training and technical assistance and focus on the development of Prevention and Early Intervention (PEI) and Innovation programs; and (2) Commission oversight for the implementation of statewide PEI projects including projects focused on the reduction of stigma and discrimination.

Ensure Perspective and Participation of Persons with Mental Illness and Their Families in Decision Making

This section describes how the Commission continues to maximize and learn from ongoing input from persons with lived mental health experience including family members.

BACKGROUND

The MHSOAC is providing this report to inform the Governor and Legislature about the Commission's activities and accomplishments during 2011, and future endeavors to meet its statutory responsibilities set forth in the MHSA and recent Assembly Bill (AB) 100 legislation. This is the Commission's

Oversight and Accountability

Oversee the Adult and Older Adult Mental Health System of Care Act, Human Resources, Education, and Training Programs, Innovative Programs, Prevention and Early Intervention Programs and the Children's Mental Health Services Act. (W&I Code §5845(a))

second Report to the Governor and Legislature on MHSOAC activities related to oversight and accountability for the MHSA and the public community mental health system in California.

Proposition 63, the MHSA, was approved by California voters in 2004 to expand and fund the new generation of best practice, recovery-driven, mental health programs across the state. The MHSA is funded through a one percent tax on personal income in excess of \$1 million. As mandated by the MHSA, the MHSOAC was established to provide oversight and accountability for the MHSA, Adult and Older Adult System of Care Act and Children's Mental Health Services Act. Taken together these programs constitute California's public community mental health system.

Until the passage of AB 100 this year, the MHSOAC had three primary roles: 1) provide oversight, review and evaluation of projects and programs supported with MHSA funds; 2) review and/or approve local MHSA funding requests; and 3) ensure oversight and accountability of the public community mental health system. With the passage of AB 100, No. 2 above no longer applies as counties no longer submit plans to the state for approval of MHSA funding.

Continuing statutory responsibilities for the Commission include:

- Advising the Governor and Legislature regarding actions the state may take to improve care and services for people with mental illness.
- Ensuring MHSA funds are expended in the most cost-effective manner and services provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers.
- Oversight, review, and evaluation of local and statewide projects and programs supported by MHSA funds.
- Ensuring adequate research and evaluation regarding the effectiveness of services being provided and achievement of outcome measures.
- Partnering with the state, to establish a more effective means of ensuring that county performance complies with the MHSA.
- Providing technical assistance to counties.
- Participating in the joint state-county decision making process for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system.
- Ensuring that the perspective and participation of persons suffering from severe mental illness and their family members are significant factors in all of its decisions and recommendations.
- Developing strategies to overcome stigma and discrimination.

OVERSIGHT AND ACCOUNTABILITY IN A CHANGING MENTAL HEALTH ENVIRONMENT

Over the past year there have been significant changes that impact California's public mental health system, the MHSA and the MHSOAC specifically. Changes include:

- The scheduled elimination of the Departments of Mental Health (DMH) and Alcohol and Drug Programs (DADP) as state departments in Fiscal Year (FY) 12/13.
- MHSA funds released directly to counties without state approval for funding or programs.

Shifting significant responsibilities for public mental health administration from the state to counties, and scheduling the elimination of DMH and DADP requires



that oversight and accountability for California's public mental health system be carefully thought out to produce the best results for California citizens and policymakers involved in making critical decisions.

With AB 100 the Governor and Legislature reiterated support for continued state oversight and focus on county performance as follows:

- "it is the intent of the Legislature to ensure continued state oversight and accountability of the Mental Health Services Act."
- "the Legislature expects the state, in consultation with the Mental Health Services Oversight and Accountability Commission, to establish a more effective means of ensuring that county performance complies with the Mental Health Services Act." (Uncodified Section 1(b) of AB 100)

Releasing MHSA funds directly to counties without state approval for funding or programs necessitates a Commission focus on identifying and ensuring avenues for oversight for the MHSA and for California's public community mental health system. Over the past year the MHSOAC has been focused on roles, activities and processes essential to meaningful oversight and accountability in this changing environment. The MHSOAC is addressing these challenges strategically in collaboration with other state entities, stakeholders, including clients and family members, local mental health departments, community mental health providers and community partners. The goal for the MHSOAC is to oversee and account for the MHSA in ways that support increased local flexibility and result in reliable outcome information documenting the impact of the MHSA on the public community mental health system in California. The Commission is committed to accounting for the impact of the MHSA on the public mental health system in ways that are measurable and relevant to local and state policymakers and California communities.

The MHSOAC has concentrated on efforts to clarify roles and identify processes, strategies and recommendations for providing effective, efficient and meaningful oversight and accountability for the public community mental health system that includes the MHSA. Those efforts over the past year include: (1) development of the MHSOAC Logic Model; (2) development of “Principles to Achieve Oversight and Accountability in a Changing Mental Health Services Environment;” (3) development of “MHSOAC’s Role in a Changing Mental Health Services Environment;” and (4) convening and facilitating an AB 100 Work Group.

MHSOAC Logic Model

The MHSOAC developed its Logic Model to ensure that its own actions are meaningful and directly linked to mental health outcomes experienced by individuals, families, communities and mental health systems. The Logic Model defines the Commission’s focus areas and strategies for oversight and accountability and reflects a commitment to evaluation and outcome reporting as an effective means to ensure that county performance complies with the MHSA.

The Logic Model delineates specific measures of system success and helps to:

- Communicate ways the Commission oversees the public community mental health system and ensures accountability
- Determine which Commission oversight strategies are most likely to be effective in overseeing and ensuring accountability for the various dimensions of a public mental health system, especially in the context of AB 100
- Delineate and link responsibilities for Commissioners, MHSOAC Committees and task-specific cross-committee work groups
- Assess the Commission’s success in oversight and accountability and its contribution to an expanded, strengthened, and cost-effective public mental health system

See Appendix A for the MHSOAC Logic Model

Roles in a Changing Mental Health Services Environment

As a result of the major administrative changes described previously, the MHSOAC developed a set of principles to inform the decisions of the Governor and Legislature regarding reorganizing state mental health programs. “Principles to Achieve Oversight and Accountability in a Changing Mental Health Services Environment,” highlights critical functions the MHSOAC recommends be maintained in this changing environment and identifies the roles and functions that should be performed by “the State” (state entity not specified) and counties that are significant to oversight and accountability for the MHSA. For example one proposed principle indicates “the State should continue to collect county data to support ongoing evaluation of California’s mental health system.”

See Link to “Principles to Achieve Oversight and Accountability in a Changing Mental Health Services Environment”

http://mhsoac.ca.gov/MHSOAC_Publications/docs/PressReleases/2011/MHSOACPrinciplesStateReorg_7-28-11.pdf

Advise the Governor and Legislature

While the principles included primarily address roles and functions that should be maintained by “the State,” another paper developed to advise the Governor and Legislature identified critical functions that the MHSOAC must exercise to fulfill its specific responsibilities. That document, “MHSOAC’s Role in a Changing Mental Health Services Environment,” identified critical functions essential to MHSOAC responsibilities in the areas of fiscal oversight, evaluation, county performance, technical assistance, stigma reduction, reducing disparities and ensuring the perspective and participation of persons with lived mental health experience and their family members is a significant factor in MHSOAC decision making and recommendations.

Examples of functions identified as important to the Commission’s responsibility for fiscal oversight and accountability include but are not limited to: analysis of county fiscal reports, tracking component allocations, monitoring prudent reserve and fund reversion and analyzing information on the condition of the Mental Health Services Fund (MHSF). To accomplish these responsibilities the MHSOAC must be able to obtain from counties, their providers and appropriate state entities, the necessary fiscal reports authorized by Welfare and Institutions Code 5845(d)(6).

See Link to “MHSOAC’s Role in a Changing Mental Health Services Environment”

http://mhsoac.ca.gov/Meetings/docs/Meetings/2011/Sep/MHSOAC_Role_ChangingMHS-Environment.pdf

AB 100 Work Group and Implementation



To address significant changes to the MHSA precipitated by AB 100, MHSOAC Executive Director Sherri Gauger, convened and facilitated an AB 100 Work Group comprised of: executive directors from DMH, the California Mental Health Planning Council (CMHPC), National Alliance on Mental Illness (NAMI), California Network of Mental Health Clients (CNMHC), California Mental Health Directors Association (CMHDA), Mental Health Association in California (MHA), United Advocates for Children and Families (UACF), and the MHSOAC. The AB 100 Work Group report identified 12 priority issues with recommendations for each. One priority issue is the need to “identify a mechanism to assure county compliance with MHSA values to replace state level review and approval of county plans eliminated by AB 100.” The Administration and the Legislature were briefed on the Work Group report and the identified issues to be addressed.

See Link to “AB 100 Work Group Report”

http://mhsoac.ca.gov/MHSOAC_Publications/docs/AB100_WorkgroupReport_ADOPTED_5-26-11.pdf

At any time, advise the Governor or the Legislature regarding actions the state may take to improve care and services for people with mental illness.(W&I Code §5845(d)(9))

FISCAL OVERSIGHT

MHSA revenues generate approximately a billion dollars per year for California's public community mental health system. Sound fiscal oversight is essential for the MHSOAC to ensure that MHSA funds are expended in the most cost-effective manner. Of critical importance during a period of financial volatility is a centralized focus on developing financial projections and analyzing actions that will impact both MHSA funding and other public community mental health funding.

As noted below MHSA revenues have been and continue to be volatile.

- MHSA revenues in FY 06/07 - \$ 984.3 million (Actual)
- MHSA revenues in FY 09/10 - \$1,394.9 million (Actual)
- MHSA revenues in FY 12/13 - \$1,117.3 million (Projected)

(Note: The dollars identified above may not tie to Annual Adjustment figures published by the Department of Finance (DOF) because DOF uses an accrual method to determine dollars and DMH and the MHSOAC base their figures on cash received.)

Given the financial volatility described and the recently proposed shift of responsibility for approval of mental health programs from the state to the counties, the MHSOAC is focused on assessing overall financial trends, identifying potential policy issues, analyzing the implications of those issues, and developing formal recommendations on solutions that support county efforts to sustain programs that demonstrate best practices and lead to positive outcomes including cost-effectiveness.

Included below are brief descriptions of the MHSOAC Financial Report, MHSOAC Budget Principles and contributions to requirements for the MHSA Annual Revenue and Expenditure Report.

MHSOAC Financial Report

In April 2009, the Commission adopted a financial framework to guide the development and issuance of regular financial reports. The financial report framework addresses the full cycle of public community mental health funding including: revenue sources (money coming in); the distribution of funding to counties (money going out); and MHSA expenditures (money utilized). These reports produced in January and May, provide key financial information related to both MHSA funds and other public community mental health funding.

Only the MHSOAC's "January" Financial Reports include revenue from the five primary funding sources for public community mental health.

- The Commission's January 2012 Financial Report identifies total revenue from the five primary funding sources for public community mental health from FY 03/04 through FY 13/14. The distribution of dollars for three of those years is as follows:

Ensure MHSA funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public (Uncodified Section 3(e) of MHSA)

	<u>FY 06/07</u>	<u>FY 09/10</u>	<u>FY 12/13</u>
1. State General Fund (SGF)	\$ 721.8 million	\$ 518.0 million	\$ -0-
2. 1991 Realignment	1,230.9 million	1,023.0 million	1,897.2 million
3. Federal Financial Participation (FFP)	1,076.8 million	1,619.2 million	1,562.5 million
4. MHSA	426.5 million	1,347.0 million	1,078.2 million
5. Other revenues	306.8 million	187.6 million	150.0 million
TOTAL	\$3,762.8 million	\$4,694.8 million	\$4687.9 million

Both January and May Financial Reports identify MHSA revenues received on a cash basis (actual, estimated and projected). May financial reports, are updated to be consistent with revenue projections contained in the Governor's May Revision.

See Appendix B and Appendix C respectively for the May 2011 and January 2012 Financial Reports.

As evidenced in the funding figures above, MHSA funds have increased as a proportion of total public funding available for community mental health. In FY 06/07 MHSA funds were only 11 percent of total funding available for public community mental health. In FY 09/10 that percentage rose to 29 percent. Current projections for FY 12/13 indicate that MHSA funds will represent approximately 23 percent of total funding available for public community mental health in California.

MHSOAC Budget Principles

Consistent with its statutory role the Commission adopted principles to help inform the Governor and Legislature regarding the one-time transfer of Mental Health Services Fund (MHSF) dollars to fund other mental health entitlement programs. The Commission identified the single most important test relative to any proposed use of the MHSF as "whether the use is consistent with the goals and values of the MHSA." Three additional budget principles identified with regard to the one-time transfer of MHSF's include: (1) minimizing the impact to existing MHSA services; (2) state assurance that the MHSA maintenance of effort and non-supplantation requirements are met; and (3) MHSOAC support for actions that create more efficiencies, enhanced cash flow to the local level, and effective use of MHSA funds while maintaining effective oversight and accountability.

See Link for "MHSOAC Principles Regarding Governor's Proposed Fiscal Year (FY) 2011/12 Budget Impact on Mental health Services Act (MHSA), February 16, 2011"

http://mhsoac.ca.gov/Meetings/docs/Meetings/2011/Feb/OAC_022411_Tab4_DRAFTPrinciplesReFY1112budget.pdf

Annual Revenue and Expenditure Report

During 2011, the MHSOAC worked with DMH and CMHDA to review and revise reporting requirements for the MHSA Annual Revenue and Expenditure Report (ARER) submitted to the state by each county. The agreed on goal for this process was streamlining reporting requirements for counties while maintaining the MHSOAC's ability to evaluate MHSA expenditures. As revised, the ARER will provide information that supports

the evaluation of: (1) the program costs and cost/benefits of Full Service Partnership (FSP) programs for various populations, including age and type of risk; (2) the costs and cost/benefits of various PEI strategies; (3) the uses of Innovation funding summarizing investments by type of innovation and outcomes; (4) the costs of previous Workforce Education and Training (WET) investments by type; and (5) summary information on investments in Community Services and Supports (CSS) and Capital Facilities/Technological Needs (CF/TN).

EVALUATION

As resources for mental health fluctuate, the MHSOAC's role to provide meaningful and effective evaluation is even more essential. Reduced resources for mental health frequently result in increased costs for mental health systems (such as costs for psychiatric hospitalization) and costs for communities (such as increased costs for law enforcement and court systems).

If however, mental health systems deliver best practice services consistent with MHSA values, both the individuals served and the community are more likely to experience improved outcomes.

The Commission is committed to:

- effective oversight and accountability that is directly linked to the evaluation of individual and system outcomes.
- an approach of continuous evaluation - learning from and building upon each progressive, completed evaluation and supporting system improvements that are critical to tracking and evaluating county outcome data.

In 2012, as a result of current evaluation efforts led by the Commission, California will report for the first time on specific county and statewide mental health outcomes from all California counties. This will allow comparison of outcome information county to county, agency to agency, and will provide the basis for the Commission's approach to continuous quality improvement. The assurance that information from evaluative efforts is used for continuous improvements based on system outcomes, is included in the Commission's accountability framework, "Accountability through Evaluative Efforts Focusing on Oversight, Accountability and Evaluation."

See link to "Accountability through Evaluative Efforts Focusing on Oversight, Accountability and Evaluation"

http://mhsoac.ca.gov/MHSOAC_Publications/docs/Publications/PolicyPaper_AccountabilityAdopted111810.pdf

The statewide outcomes to be reported are available from collecting and measuring categories of information identified as being important to mental health. Previous research and evaluation has demonstrated that some mental health outcomes are better "indicators" of system performance than others. As such the outcomes to be reported are from analyzing specifically chosen "mental health indicators" that have priority importance. While this type of data collection and analysis has long been considered essential to understanding individual and system outcomes in the public mental health

system, consensus among state and local entities about methodology and process was never achieved to allow for statewide reporting. Although some counties and agencies participating in pilot/demonstration programs implemented prior to the passage of the MHSA did produce ongoing outcome information, not all counties were part of those pilot/demonstrations.

In 1991, mental health realignment statutes included provisions related to some type of uniform statewide county reporting on important mental health indicators. Despite much effort, this reporting never came to pass. One notable exception was county outcome reports produced by DMH analyzing information from consumer perception surveys. Twenty years later, as a result of significant work by the California Mental Health Planning Council (CMHPC) to develop a set of priority indicators, the Commission not only adopted those indicators but chose to make a specific investment in evaluation that will produce standardized outcome reports by county and statewide. As such, this long term goal for California's mental health system will be realized with reporting beginning in 2012. Other evaluation efforts described in this report either have or will produce critical information necessary to assess the impact of the MHSA on the public community mental health system in California.

The Commission believes ongoing evaluation and local outcome tracking and reporting is an effective and meaningful way to meet its statutory responsibilities for the cost-effectiveness of services, best practice, and county performance that complies with the MHSA, particularly with MHSA funds going directly to counties without state approval. State and local entities are in agreement that rules, regulations and reporting requirements should be revised to provide local flexibility and be streamlined so that only the most essential requirements remain. To assess the impact of the MHSA in California, no information is more significant and essential than actual individual and system outcome information from counties across California.

Reportable Findings from Recent MHSA Evaluation Efforts

Results and findings from recent MHSA evaluation efforts include:

- **Activity and Expenditure Information for Local MHSA Programs**

A UCLA report on activities and expenditures for local MHSA funds has produced baseline information necessary to understand MHSA expenditures.

The following are examples of information contained in the report, which summarizes information through 2009.

1. Consistent with regulation, the majority (more than 50 percent) of MHSA expenditures were for CSS, FSP programs.
2. The MHSA is increasingly shouldering a larger share of cost for California's public community mental health system as funding from 1991 Realignment and the General Fund is reduced.

- **UCLA Study Confirms Positive MHSA Outcomes**

For more than six years, pilot/demonstration programs cited in the Act as model programs for expansion under the MHSA, produced ongoing, reliable, outcome information about individual and system outcomes that was overwhelmingly positive. As such, they showed evidence that investment in best practice mental health programs, produced not only improved life outcomes for the persons served, but improved and cost-effective system and community outcomes that included reduced jail days, hospital days, and homeless days. Although outcome reporting for those programs ended when funding was eliminated and only included counties and agencies participating in the pilot/demonstration programs, FSP programs established by the MHSA, and the design for MHSA outcome reporting was based on methodologies used in the model programs. University of California, Los Angeles (UCLA) studied other statewide and local efforts to confirm the effectiveness of FSP programs and the impact of participation in CSS programs on client outcomes. CSS is one of three “service” components funded by the MHSA.

Information from this study indicated:

- A strong association between CSS, FSP program participation and reduced acute psychiatric hospitalization
 - A strong association between CSS, FSP program participation and reduced arrests
 - An overall trend of reduced physical health emergencies during CSS, FSP program participation
 - Positive trends in education outcomes
 - Overall trend of improved mental health functioning and quality of life for adults and older adults participating in CSS, FSP programs
- **Geo-mapping Effort Identifies Need For and Use of Mental Health Services in California**

Among the Commission’s responsibilities is improving access to mental health services, particularly for persons who are part of underserved population groups. Functions important to this responsibility include producing data that measures the service levels to un-served and underserved communities, accessing both county and state level data on this outcome, and tracking efforts to reduce disparities in access and outcomes. The University of California – Davis, (UCD) recently completed a ground-breaking “geo-mapping” effort that identifies the localized need for and use of mental health services in California. Geo-mapping enables layers of data from various sources like California Medi-cal data and U. S. Census data to be recorded on a geographic map to be visualized and analyzed. As a result of the Commission’s efforts, geo-mapping results may be used to assist individual counties to plan and perform on-going analyses to track the quality and cost-effectiveness of care, and improve service access, delivery and quality.

- **Analysis of the California Health Information Survey (CHIS) – Mental Health Data**

Focused on disparities in mental health care, UCD recently completed a detailed analysis of 2007 data from the mental health component of the California Health Information Survey (CHIS). The purpose of the analysis was to study the information available from CHIS and provide specific recommendations on the design of a follow-up survey necessary to obtain a more accurate baseline assessment of mental health needs and treatment utilization in California. One recommendation related to increasing the accuracy of baseline data was to increase the survey sample size for low-income persons.

Focus of Current MHSOAC Evaluation Efforts

MHSOAC evaluation efforts currently underway will produce additional information and findings about the impact of the MHSA on California's public community mental health system. The Commission looks forward to reporting on findings from the following evaluation efforts in its next report.

- **Analysis of FSP Cost Per Client and Cost Benefit Analysis**

Information from a current analysis of FSP program costs and costs per client will be reviewed in the context of FSP outcome information to allow for comprehensive analysis of the effectiveness of FSP programs and other quality evaluations by the Commission.

- **Review and Analyze Reports on Priority Mental Health Indicators**

As discussed, an important and historical step in understanding and measuring the statewide impact of the MHSA is the development of a standardized template for reporting statewide and county specific outcomes on mental health priority indicators. The Commission's specific investment in this effort will produce standardized outcome reports by county and statewide. So that information is reported consistently by all counties, a template developed by UCLA, will identify specific sources of information that can be documented and the calculations to be used to report on indicators identified for CSS. It is expected that in 2012, UCLA will issue the first report on county performance using the standardized template and reporting outcomes from specific mental health indicators. Outcome areas addressed in the report will include school attendance/employment, involvement with criminal justice, homelessness and health. Analysis of these reports will assist the MHSOAC to determine if desired effects are being achieved, and if not, what changes might be made to improve client, family, and system outcomes. The Commission's focus on standardized performance indicators is consistent with federal efforts and will be aligned with the National Outcomes Measurement System (NOMS).

- **Improvements to Data Collection Reporting System**

Information reported through the Data Collection Reporting (DCR) system is client-specific outcome information on persons served in MHSA FSP programs. This information is essential to evaluating the effectiveness of

FSP programs on both individual and system outcomes. It is imperative that counties are able to use the DCR system efficiently and submit data that is valid and complete. Due to a lack of resources counties have not received regular reports, feedback or technical assistance to identify problems with their reported FSP data. To address these problems the Commission entered into a contract with California State University, Sacramento (CSUS) to strengthen and improve the DCR system maintained by DMH. This investment by the Commission is critical in ensuring the DCR's data quality and helping counties to better understand and improve their reporting.

With the exception of hospitalization data available through the DMH Client Services Information (CSI) system, DCR data is the only client outcome information provided by counties on persons specifically receiving MHSA services. As such it is used extensively in analyzing the effects of the MHSA in California. DCR data combined with information on FSP program costs and cost per client will allow for comprehensive analysis of the effectiveness of FSP programs and quality evaluations by the MHSOAC.

This DCR system reports client-specific outcomes that include but are not limited to:

- housing or residential status
- criminal justice involvement
- co-occurring conditions
- education
- employment
- emergency interventions

CSUS will: (1) develop a user-friendly data dictionary and DCR system manual; (2) provide a one-time county-level data quality report of basic client information as well as identify the number of completed and missing forms in the system; and (3) provide counties with templates, curriculum, trainings, and e-training materials on the effective use of the DCR system.

• Build Upon Previous Evaluation Efforts

The Commission intends to build upon past evaluation efforts, utilize what has been learned and expand the scope of future evaluations to address additional areas of focus. The benefit of this incremental approach is the ability to learn from current research, identify new questions to be answered and determine what additional evaluation components would best expand our understanding of the impact of the MHSA on the public community mental health system. In November 2011, the Commission considered how best to spend additional funds recently approved by the Legislature for MHSOAC evaluation activities. The Commission adopted recommendations that include: (1) evaluating a subset of early intervention programs; (2) obtaining information regarding the impact on mental health disparities; and (3) ongoing support for county DCR system data validation and use of reports. The MHSOAC is also partnering with the California Mental Health Services Authority (Cal-MHSA) and the Rand Corporation to create, for Commission approval, a statewide, sustainable evaluation system and framework for PEI.

OVERSEE, REVIEW, AND EVALUATE LOCAL AND STATEWIDE MHSA PROJECTS AND PROGRAMS

Meeting the Commission's comprehensive responsibility for oversight, review and evaluation of local and statewide MHSA projects and programs requires activities in addition to fiscal oversight and the specific evaluation activities described previously. This section describes additional ways the Commission supports county performance and oversees the implementation of statewide PEI projects, including projects focused on the reduction of stigma and discrimination.

Training and Technical Assistance

AB 100 amended the MHSA to authorize the MHSOAC to "provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the commission or when local programs could benefit from technical assistance for improvements" A further provision of the Act provides that the MHSOAC may "participate in the joint state-county decision making process . . . for training, technical assistance, and regulatory resources to meet the mission and goals of the state's mental health system."

Supporting California counties, including their community partners, clients, family members, stakeholders and contractors, to plan, implement, and evaluate mental health services, is critical to achieving the type of system transformation envisioned in the MHSA and to ensuring that county performance complies with the MHSA.

A key role for the MHSOAC is to coordinate the effective use of training and technical assistance resources and emphasize the use of local evaluation data and outcomes for continuous improvement of the public community mental health system. In 2010 and 2011 MHSOAC staff worked closely with DMH to oversee the provision of training and technical assistance by the California Institute for Mental Health (CiMH) focused on PEI and Innovation programs. These efforts included presentations, webinars, learning groups, and online curricula focused on evaluation. When requested, the Commission also provided extensive training and technical assistance to counties to assist in their preparation of PEI and Innovation work plans and Annual Updates.

As another form of technical assistance, the Commission also supports ongoing county performance by developing and making available written products that identify mental health system strategies most likely to produce positive individual and system outcomes. The Commission's efforts in 2011 include an update to a previous report and one new report as described below.

Update to Commission's Report on Co-occurring Disorders and Focus on Integrated Services

Previously the Commission authorized a 19-member, Public-Private Sector Work Group on Co-occurring Disorders (COD). The Work Group was charged with developing comprehensive recommendations to address the needs of people who have the co-occurring conditions of mental illness and

The commission may provide technical assistance to any county mental health plan as needed to address concerns or recommendations of the commission or when local programs could benefit from technical assistance for improvement of their plans. (W&I Code §5846(b))

substance use. The report was adopted by the Commission and currently almost 84 percent of 55 recommendations are complete or in process. A related focus has been on transformation through integration. This is seen as a course of action to improve the quality and effectiveness of California's mental health and addiction services. The MHSOAC recognizes the issue of co-occurring mental health and substance-use disorders can only be addressed through a transformed public mental health system where programs and services are integrated at the level of service experience for clients, family members and caregivers, with an identified single point of responsibility for individual service planning and commitment to outcomes. In light of the administrative system changes proposed for mental health and the governance transition of mental health and alcohol and drugs, the remaining recommendations require review and reprioritization for action by the MHSOAC and its partners.

See Link to "Report on Co-Occurring (COD) Status to Date, June 2011"
(http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Jun/Services_060911_Tab5-CODReportUpdate.pdf)

Transformation Policy Paper

The MHSOAC's Client and Family Leadership Committee (CFLC) is one way the Commission obtains ongoing input from clients and family members with lived experience of mental illness and treatment either personally or by family relationship. Given the Committee's expertise, the CFLC was charged with developing a policy paper for the Commission on transforming the mental health system through client and family leadership. The policy paper entitled "Client-driven, Family-focused Transformation of the Mental Health System through the California Mental Health Services Act" reflects the shared vision of the MHSA and the MHSOAC as follows:

- The MHSA provides a comprehensive vision for mental health systems focused on recovery and resiliency and informed by the lived experience of clients and family members.
- The MHSOAC was established to oversee all of the elements of the MHSA and charged with ensuring that the lived experience of clients and family members would inform its decisions and provide continuous guidance.
- The MHSOAC policy paper presents a picture of a mental health system "transformed" in the way it values, utilizes and promotes the voices and wisdom of clients and family members.

This policy paper is not about including clients and family members in planning, policy, and service delivery just for inclusion's sake. The vision of transformation depicted in this paper is driven by the experience and inherent understanding the client/family community has developed about what works and what does not, and how systems can utilize that expertise to achieve radically better outcomes for systems and the individuals they serve.

This paper, adopted by the MHSOAC in May 2011, presents both a broad vision and specifics of how things would look in a mental health system routinely and continuously informed by clients and family members with lived mental health experience. As presented, the paper identifies "broad goals" by subject area for transforming the mental health system through client and

Develop Strategies to Overcome Stigma

Develop strategies to overcome stigma and accomplish all other objectives of Part 3.2 (commencing with Section 5830), 3.6 (commencing with Section 5840), and the other provisions of the act establishing this commission. (W&I Code §5845(d)(8))

family leadership and provides comprehensive descriptions of what it will take to achieve those goals. It is expected that this paper will serve as a guide for local stakeholders and policymakers looking for specific ways to improve and transform their mental health system. As such it is intended to provide information directly relevant to improved county performance.

See Link to “Client-driven, Family-focused Transformation of the Mental Health System through the Mental Health Services Act”

(http://mhsoac.ca.gov/MHSOAC_Publications/docs/Publications/CFLC_TransformationPolicyPaper_May2011.pdf)

PEI Statewide Programs

A specific responsibility for the Commission named in the MHSA is to develop strategies to overcome stigma. Given the negative outcomes attributable to and the scope of stigma and discrimination toward persons with mental illness and their families, the MHSOAC approved the use of MHSA PEI funds for four “statewide” programs including one focused on the reduction of stigma and discrimination. The intent for developing statewide PEI programs was that they would result in projects: (1) having a statewide impact; (2) being implemented more efficiently and effectively; and (3) providing a statewide foundation for counties to build upon for long lasting results.

The MHSOAC approved the following four PEI Statewide Programs:

- Stigma and Discrimination Reduction - \$15 million per year for four years
- Suicide Prevention - \$10 million per year for four years
- Student Mental Health - \$15 million per year for four years
- Reducing Mental Health Disparities - \$15 million per year for four years

Although program strategies and activities to be implemented will vary among the four programs, there is a correlation among them as described below.

Untreated mental illness is among the leading causes of disability and suicide and imposes high costs on state and local government.

Stigma and discrimination against persons with mental illness and their family members is a significant factor in persons choosing not to seek mental health services.

Frequently students do not seek help for mental health issues due to stigma and discrimination.

Disparities in the use of mental health services may result from stigma and discrimination and lead to untreated mental illness and associated negative outcomes including suicide.

Suicide among youth attending school is prevalent.

Dynamics involving the abuse of people with lived experience of mental illness, as well as stigma and discrimination towards such people, their family members and the mental health professional community, are pervasive across lines of community, race, ethnicity, economic class, profession, media

Develop Strategies to Overcome Stigma

Develop strategies to overcome stigma and accomplish all other objectives of Part 3.2 (commencing with Section 5830), 3.6 (commencing with Section 5840), and the other provisions of the act establishing this commission. (W&I Code §5845(d)(8))

and popular cultures. The barriers that result from these dynamics cause great harm to groups and individuals, impede knowledge of and access to much needed services, prevent a broader understanding of and support for mental health and the communities affected by mental health challenges, and block individuals from achieving their life aspirations in areas including career, housing and education. Statewide PEI programs aimed at preventing suicide, improving student mental health and reducing disparities in access to and use of mental health services will all address reducing stigma and discrimination.

The California Mental Health Services Authority (Cal-MHSA), a Joint Powers Authority, has contracted to implement multiple statewide PEI programs focused on reducing stigma and discrimination, suicide prevention and student mental health. Programs focused on reducing stigma and discrimination and suicide prevention include multiple strategies and activities such as major media campaigns and local and regional capacity building efforts. Student mental health programs include statewide and regional activities for K-12 and higher education through California State Universities, Universities of California and California Community Colleges. K-12 activities include ongoing training for educators, parents/caregivers and community partners. Key activities for higher education programs include addressing the mental health needs of student veterans. Evaluation efforts for some projects have begun with the development of software for program tracking, data management and communication. The Commission looks forward to reporting further on these efforts in next year's report.



The fourth statewide PEI project approved by the Commission is the California Reducing Disparities Project (CRDP) focused on reducing disparities in access to, use of, and outcomes of mental health services by population groups traditionally underserved. These groups include African Americans, Asian/Pacific

Islander, Latino, Native Americans and Lesbian, Gay, Bi-Sexual, Transgender and Questioning (LGBTQ). Currently the DMH Office of Multicultural Services has contracted for input from each of the population groups identified to develop a Strategic Plan intended to guide statewide efforts to reduce mental health disparities. The Commission will develop guidelines describing the appropriate expenditure of PEI statewide funds for statewide projects focused on reducing disparities.

Related Public Information Efforts

The Commission is continuing to enhance its public communication strategy to ensure the effectiveness of the MHSA is communicated statewide and to reduce stigma and discrimination toward persons with mental illness and their families through ongoing public dialogue. In February 2011, Public Broadcasting System broadcast a national program focused on a San Francisco teenager being served in a PEI program, whose mental illness was diagnosed early with successful results. The program, entitled "California Program Stresses Early Detection, Treatment of Mental Illness"

came about as a result of public information efforts by the Commission. Current Chair of the Commission, Larry Poaster, Ph.D., current Commissioner and former Chair, Andrew Poat, and Commissioner Eduardo Vega had op-ed articles published in the Modesto Bee, San Diego Union Tribune, and San Francisco Chronicle, respectively. Response to these articles generated other positive newspaper articles about MHSAs funds being hard at work and led to the national PBS program described.

Prevention and Early Intervention (PEI) Trends Report

As set forth in the MHSAs, PEI services are designed to:

1. prevent mental illness and emotional disturbance from becoming severe, disabling and costly to individuals, families, communities and the State
2. reduce the negative effects of untreated mental illness including:
 - suicide
 - homelessness
 - incarceration
 - school failure or drop out
 - removal of children from their homes
 - prolonged suffering
 - unemployment
3. improve access to mental health services especially for persons who are un-served, underserved, or inappropriately served
4. facilitate the earliest possible identification of and response to signs of mental health problems and concerns
5. offer mental health prevention and early intervention services at sites where people go for other routine activities such as primary care, schools, and family resource centers
6. reduce stigma and discrimination related to mental illness

In 2010 the Commission published a “PEI Trends Report” based on the review of county PEI Plans submitted to the MHSOAC for review and approval. The “2011 PEI Trends Report” updates the Commission’s prior year report and provides information from the review of 485 PEI program plans submitted by California counties. The “PEI Trends Report” compiles and describes the PEI programs counties intended to implement and sought approval to establish. This “baseline” analysis of PEI programs counties planned to develop is expected to be helpful when reviewing and analyzing actual PEI programs established statewide.

As described in county PEI Plans:

- Every county in California planned to establish at least one PEI program focused on “at-risk children, youth, and young adult populations”
- At least 75 percent of counties included one or more programs to address reducing school failure, stigma and discrimination, incarcerations and prolonged suffering as a consequence of mental illness

- 86 percent of counties included a program element to address co-occurring mental health and substance-use issues in at least one PEI program
- 78 percent of counties included at least one PEI program to address the negative effects of trauma
- A number of counties prioritized programs that focused explicitly on the needs of specific racial and ethnic groups
- Most PEI services will be provided at sites where people go for other routine activities including schools, community-based organizations, primary care, diverse social and community settings, homes, faith-based organizations and childcare or pre-school.

See Link to “2011 PEI Trends Report”

(http://www.mhsoac.ca.gov/meetings/docs/Meetings/2011/May/OAC_052611_Tab3_PETrends051111.pdf)

Innovation Trends Report

The Innovation component of the MHSA provides an opportunity for California to develop and test new mental health models with the potential to become tomorrow's best practices. The MHSA stated purposes for Innovation programs are to:

- Increase access to services
- Increase access to underserved populations
- Improve the quality and outcome of services
- Promote interagency collaboration

Through the Innovation component counties design and test new or adapted programs and strategies with the potential to improve mental health delivery consistent with the MHSA-specified purposes identified above. Like the “PEI Trends Report,” the MHSOAC’s “Innovation Trends Report” analyzed 84 individual Innovation program plans submitted by 31 counties for MHSOAC approval. The report is entirely based on reviewing plans for programs that counties intended to implement, not on the review of Innovation programs already established.

As described in county plans for Innovation programs, some of the major areas in which new mental health approaches are being developed, piloted, and evaluated by county Innovation programs include:

- Treatment approaches for transition-age-youth, including youth exiting the foster care system
- Alternative responses to mental health crises, including those involving criminal justice
- Expanded contributions to service design and delivery by persons with mental illness and their family members
- Community-based prevention, early intervention and treatment models by and for diverse populations
- Comprehensive and integrated approaches for individuals with co-occurring mental health and physical health issues and/or substance-use issues

Ensure Perspective and Participation

Ensure perspective and participation of members and others suffering from severe mental health and their family members is a significant factor in all of its decisions and recommendations (W&I Code §5846(c))

The MHSOAC has provided support to the CiMH in developing training and technical assistance for counties' Innovation efforts, including topic-based learning groups and an interactive e-learning curriculum on evaluation for Innovation that helps counties identify effective program elements that should be replicated and disseminated.

See Link to "Innovation Trends Report"

http://mhsoac.ca.gov/MHSOAC_Publications/docs/Publications/INN_Trends_2012_FINAL_wAppendices.pdf

ENSURE PERSPECTIVE AND PARTICIPATION OF PERSONS WITH MENTAL ILLNESS AND THEIR FAMILIES IN DECISION MAKING

Consistent with MHSA values, the Act requires the Commission to ensure that the perspective and participation of persons with mental illness and their family members is a significant factor in all of its decisions and recommendations. The MHSOAC is involved in multiple activities to increase, sustain and learn from the expertise of persons with lived mental health experience including family members. Some of these efforts include hosting public community forums throughout California to hear directly from persons receiving mental health services and their families about their experiences both positive and negative. Other efforts include involving clients and family members in "participatory research" conducted through the UCLA evaluation of the MHSA and conducting an MHSOAC Quality Improvement Survey soliciting input from over 1000 individuals on the Commission's subscriber list.

Community Forums



In 2010 the Commission began hosting Community Forums in various communities throughout California. These Forums provide opportunities for the Commission to hear firsthand from persons receiving mental health services and their families about their experience with services and the MHSA.

To ensure travel costs are kept to a minimum recent Forums have been held in locations that allow staff to travel together by car and return the same day. Two recent Forums in San Francisco and Modesto were the largest Forums to date with almost 150 participants in San Francisco and 200 in Modesto not including Commissioners and staff. For the first time at the San Francisco Forum and again in Modesto, participants were given the opportunity to fill out a questionnaire to be returned to MHSOAC staff. This process is providing excellent feedback and will be used in the annual report to the Commission on outcomes and findings from the Forums. A total of three Community Forums were held in 2011.

Participatory Research

The UCLA evaluation of the MHSA will include "participatory research" as one evaluation approach used to evaluate the cost benefit of the MHSA.

Under this methodology UCLA will work in partnership with those persons affected by the evaluation, including individuals living with mental illness, their families and caregivers, and persons from traditionally un-served or underserved communities, across all age groups. This collaborative process will determine the priorities for what is studied as well as where, when and how it is studied. This approach also allows all partners to contribute their expertise to enhance everyone's understanding of the research question, design, implementation and interpretation of the outcomes. UCLA's current evaluation efforts include clients and family members in its study of the impact of the MHSAs in the areas of crisis and employment.

Quality Improvement Feedback

The Commission is committed to communicating with partners, stakeholders, and other mental health advocates to evaluate ways the MHSOAC can improve its efforts. To further this goal the Commission asked for the development of a Quality Improvement Survey that would allow the Commission to analyze its performance and make conscious efforts to improve operations and increase strengths. The 25-question survey was conducted using an online website in April 2011. From the MHSOAC subscriber list, 1,076 individuals were invited to participate in the survey – 210 surveys were submitted. The survey showed an overall positive perception of the Commission's operations. The few areas identified for improvement will be addressed in 2012.

See Link to MHSOAC Quality Improvement Survey

(http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2011/Nov/OAC_111711_TabCorrespondence_QISurveyReport.pdf)

MHSOAC Next Steps

Continue Evaluation and Report Activities

The Commission is charged with: (1) overseeing, reviewing and evaluating state and local projects and programs supported with MHSAs funds; and (2) ensuring adequate research and evaluation regarding the effectiveness of services being provided and achievement of outcome measures. As previously discussed, in leading ongoing evaluation efforts the Commission is also meeting its responsibility to establish a more effective means of ensuring that county performance complies with the MHSAs. Evaluation reports and studies made available from evaluations currently being conducted by UCLA and UCD will be analyzed and used by the MHSOAC to identify, plan, and inform future evaluation efforts as well as advise California policymakers on the impact of the MHSAs on individuals and systems statewide.

In 2012 information and findings from the first county specific reporting on priority mental health indicators will be available. The MHSOAC will analyze these findings and develop recommendations regarding ongoing reporting of county performance. Building on UCLA studies about local implementation of PEI programs, next steps include: (1) developing a small set of priority PEI indicators or measures to be collected by counties; and (2) providing technical assistance to support counties' capacities to analyze and interpret outcomes and enhance overall evaluation of the MHSAs. Additionally, the MHSOAC will continue to report on PEI and Innovation trends occurring

statewide. The Commission's goal for continued evaluation is to produce reliable information that documents the impact of the MHSA on life outcomes for persons and families served by the mental health system and for systems and communities. The Commission will continue its commitment and efforts to account for the impact of the MHSA in ways that are measurable and relevant to local and state policymakers and California communities.

Continue Collaboration with State Entities, Counties and Stakeholders to Ensure MHSA Values and Outcomes are Accomplished

The Commission will continue to implement AB 100 by collaborating with state entities, counties, and stakeholders to establish a more effective means of ensuring that county performance complies with the MHSA. The Commission will also continue to collaborate and advise on regulations, policies, procedures and other processes that will support meaningful and improved oversight and accountability for California's public community mental health system in a post-AB 100 environment.

Specific tasks for the Commission in 2012 will include working with DMH, the Department of Health Care Services (DHCS), CMHDA and stakeholders to review current MHSA regulations to determine which should continue, be revised and/or be repealed. Additionally, the Commission will continue its efforts to support strengthening the data infrastructures that provide critical information necessary to perform effective MHSA program evaluations.

Conclusion

The MHSAOAC has always had a statutory responsibility to advise the Governor and Legislature regarding actions the state may take to improve care and services for persons with mental illness. As such the Commission's focus going forward will include continued advice to and collaboration with the Administration, Legislature, county mental health leadership, other community providers, and mental health stakeholders, about managing the state administrative and system changes in a way that will produce improved life outcomes for individuals and families living with mental health challenges, positive system outcomes for mental health and other community partners, and positive outcomes for California communities.

The Commission is confident that it can provide the critical information necessary for California citizens and policymakers to assess the impact of the MHSA on California's public community mental health system. As described in this report, Commission actions and strategies to accomplish this are focused on expanding statewide evaluation of the MHSA and producing reliable information expected to document an improved mental health system in California.

With the elimination of DMH, the Commission looks forward to working with state entities, counties and stakeholders to ensure that the values and intended outcomes established by the Act continue to be realized.

About the Cover

The artwork on the cover is a compilation of artwork submitted to the MHSOAC for use in our art newsletter *Expressions*.



Give It A Chance

By Gabriel Gonzales

A message from the artist:

I got the idea from a plate. It just progressed from there. The meaning is Peace can be served to us all.



Inside A Wounded Mind

By Sheila Dery



Cityscape

By Michael Johnson

A message from Michael's mother in memoriam:

Michael wanted to live in New York, he dreamed of being an NBA basketball player, an artist, a musician or a chef--all dreams built on areas of his life where he had shown talent. In these ways, Michael was gifted, but he struggled with other parts of his life. He overcame so many obstacles as a child--stuttering, reading problems, and other language-related learning disabilities--I was amazed how he kept on trying. He misunderstood social cues and was confused when people got angry with him. Underneath the persona he learned to cultivate to succeed socially, was that same kid who needed and struggled to be accepted.



Pair of Pears

By Margo G.





Sunflowers

By Lisa Stetler

A message from the artist:

When I was diagnosed with PTSD, Borderline Personality and Major Depression I was homeless and (the) Department of Behavioral Health helped me find a home. I now have my own apartment and volunteer. I just finished classes to earn a Peer Advocate Certificate.



Journey of Hope

By Dianne Mattar

A message from the artist:

Emotion is at the base of my art, my mission is to touch others with 'hope, joy and encouragement' with bright bold color... Mental well-being is the foundation to overall well-being, when we accept and then push forward and (through) we encourage others as we heal.



I Am

By Roni J. Hanke

A message from the artist:

The piece "I Am" was created from the experience of many who are forced to hide who they are because of discrimination. These people are everywhere mistreated, misdiagnosed, misunderstood, and ultimately feeling alone. Unless people are talking about their differences in a positive light no one will ever know there are others just like them.



Mother Nature

By Sheila Dery

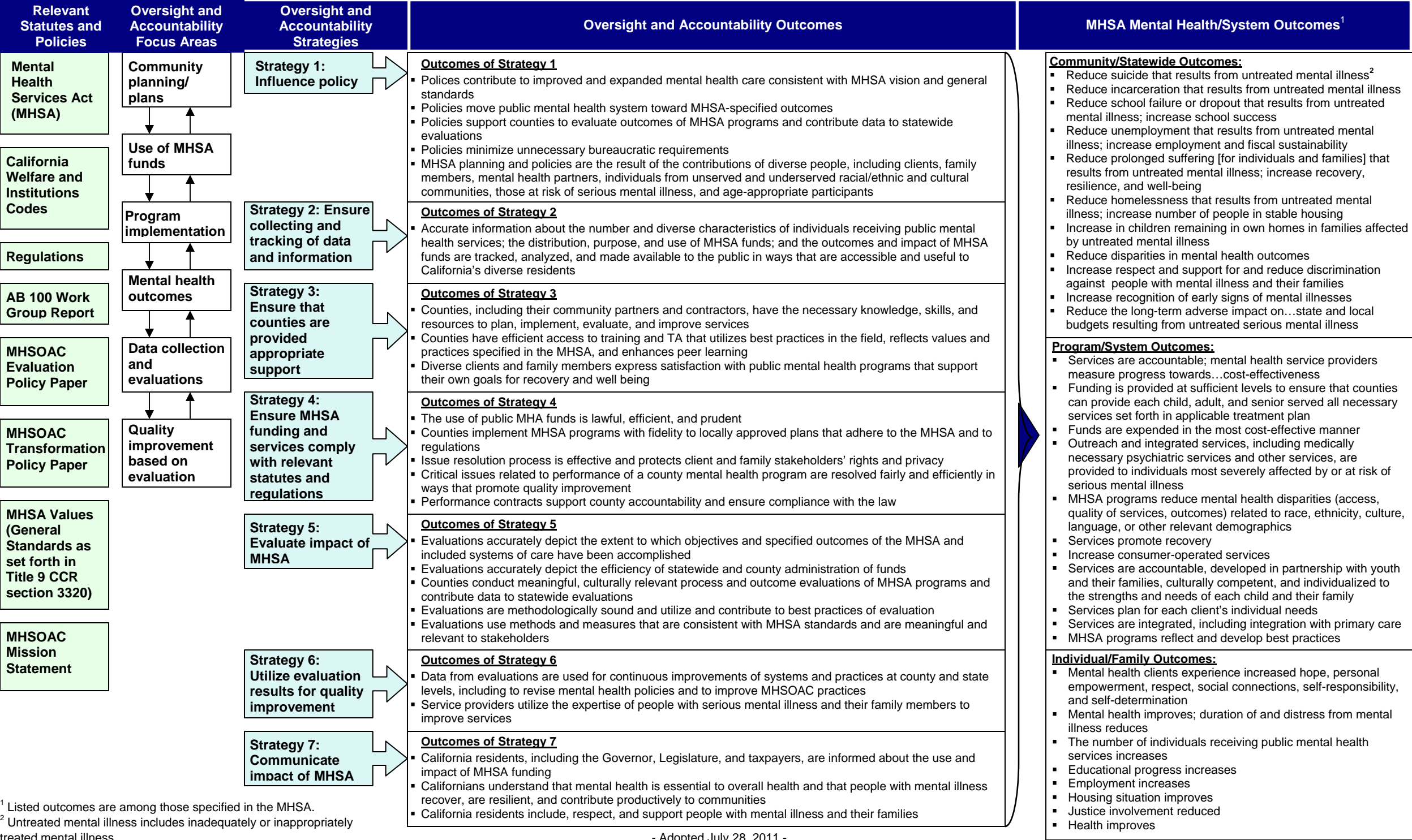


Old Western

By Margo G.



Appendix A California Mental Health Services Oversight and Accountability Commission (MHSOAC) Logic Model



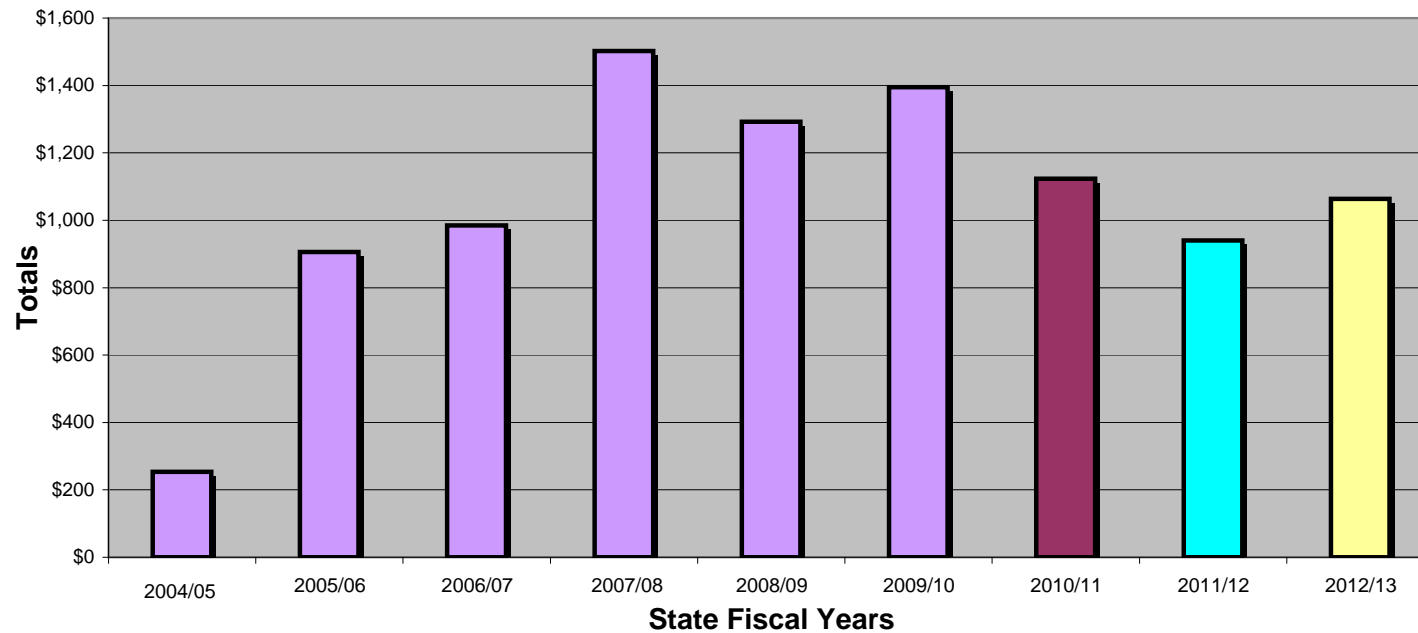


**Mental Health Funding & Policy Committee
Financial Report
May 26, 2011**

5/26/2011

MHSA REVENUES RECEIVED (Cash Basis) (Millions)

FY 2004/05 through 2012/13

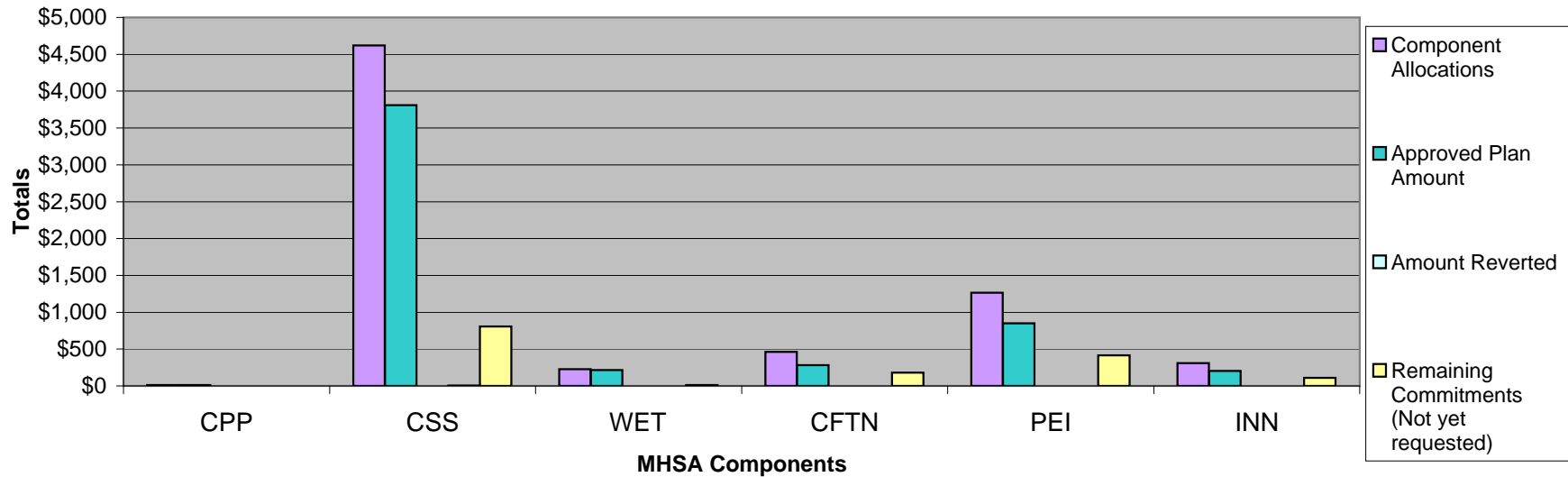


	SFY 04/05 (actual)	SFY 05/06 (actual)	SFY 06/07 (actual)	SFY 07/08 (actual)	SFY 08/09 (actual)	SFY 09/10 (actual)	SFY 10/11 (estimated)	SFY 11/12 (projected)	SFY 12/13 (projected)
Cash Transfers	169.5	894.6	935.1	\$983.9	\$797.0	\$799.0	\$895.0	\$1,004.0	\$1,085.3
Annual Adjustment	83.6	\$0.0	\$0.0	\$423.7	\$438.0	\$581.0	\$225.0	-\$64.5	-\$23.0
Interest Income	0.7	\$11.2	\$49.2	\$94.4	\$57.6	\$14.9	\$3.4	\$0.8	\$0.8
TOTAL	\$253.8	\$905.8	\$984.3	\$1,502.0	\$1,292.6	\$1,394.9	\$1,123.4	\$940.3	\$1,063.1

A comparison of MHSA revenues on an accrual basis and a cash basis can be found in the Department of Mental Health's (DMH) MHSA Expenditure Report for FY 2011/12 at http://www.dmh.ca.gov/Prop_63/MHSA/Publications/default.asp

Source: FY 2011/12 Governor's Budget May Revision and DMH MHSA Expenditure Report (FY 04/05 through 11/12 amounts)
FY 12/13 cash transfers are projected based on personal income tax estimates from the 2011/12 May Revision Revenue Estimates.
Estimated numbers are for FY 10/11 and projected numbers are for FY 11/12 and 12/13.

**MHSA Funding
Committed/Distributed/Undistributed/Reverted
FY 2004/05 through 2011/12
(millions)**

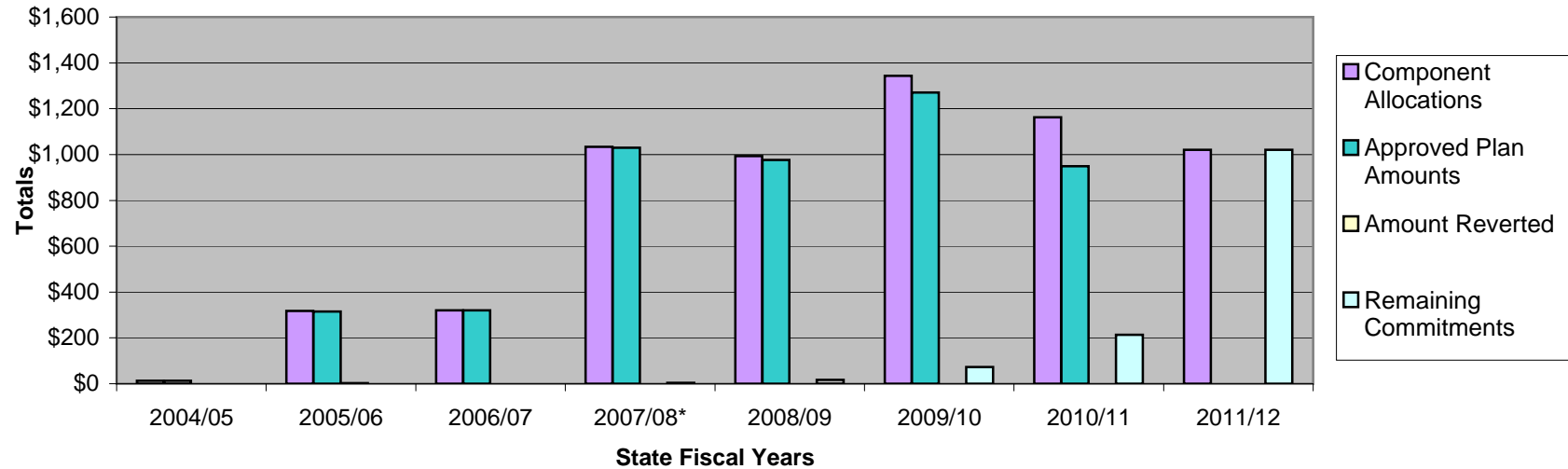


MHSA Funding: County-Level Committed/Distributed/Undistributed/Reverted (By Fiscal Year) 2004/05 through 2011/12				
	Component Allocations	Approved Plan Amount	Amount Reverted	Remaining Commitments (Not yet requested)
2004/05	\$ 13.0	\$ 12.7	\$ 0.3	\$ 0
2005/06	\$ 317.3	\$ 315.2	\$ 2.1	\$ 0
2006/07	\$ 426.3	\$ 423.5	\$ 0	\$ 2.8
2007/08	\$ 1,488.1	\$ 1,380.9	\$ 0.2	\$ 107.0
2008/09	\$ 1,117.0	\$ 1,018.0		\$ 99.0
2009/10	\$ 1,347.0	\$ 1,272.1		\$ 74.9
2010/11	\$ 1,165.4	\$ 951.4		\$ 214.0
2011/12	\$ 1,020.9			\$ 1,020.9
Total (FY 04/05 - 11/12)	\$ 6,895.0	\$ 5,373.8	\$ 2.6	\$ 1,518.6

Source: DMH MHSA Summary Comparison (Posted 5/12/2011)

5/26/2011

**MHSA Funding: Combined CSS, PEI and INN
Committed/Distributed/Undistributed/Reverted
FY 2004/05 through 2011/12
Three Year Reversion
(millions)**



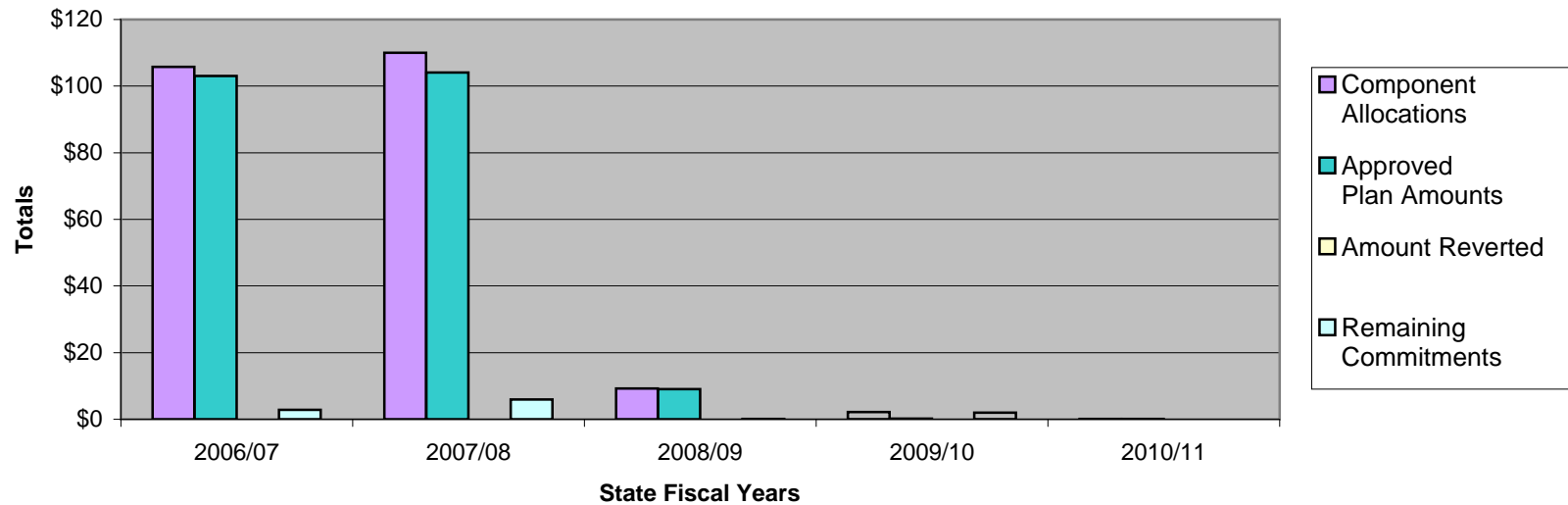
MHSA Funding: County-Level Committed/Distributed/Undistributed/Reverted (By Fiscal Year) 2004/05 through 2011/12				
	Component Allocations	Approved Plan Amounts	Amount Reverted*	Remaining Commitments
2004/05	\$ 13.0	\$ 12.7	\$ 0.3	\$ 0
2005/06	\$ 317.3	\$ 315.2	\$ 2.1	\$ 0
2006/07	\$ 320.5	\$ 320.5	\$ 0	\$ 0
2007/08	\$ 1,033.2	\$ 1,029.6	\$ 0.2	\$ 3.3
2008/09	\$ 993.7	\$ 976.6		\$ 17.1
2009/10	\$ 1,343.6	\$ 1,270.7		\$ 72.9
2010/11	\$ 1,163.0	\$ 949.0		\$ 214.0
2011/12	\$ 1,020.9			\$ 1,020.9
Total	\$ 6,205.1	\$ 4,874.3	\$ 2.6	\$ 1,328.3

*Reversion based on Unapproved Funds only. Reversion based on Unexpended Funds not yet determined

Source: DMH MHSA Summary Comparison (Posted 5/12/2011)

5/26/2011

**MHSA WET Funding
Committed/Distributed/Reverted
FY 2006/07 through 2010/11
Ten Year Reversion
(millions)**

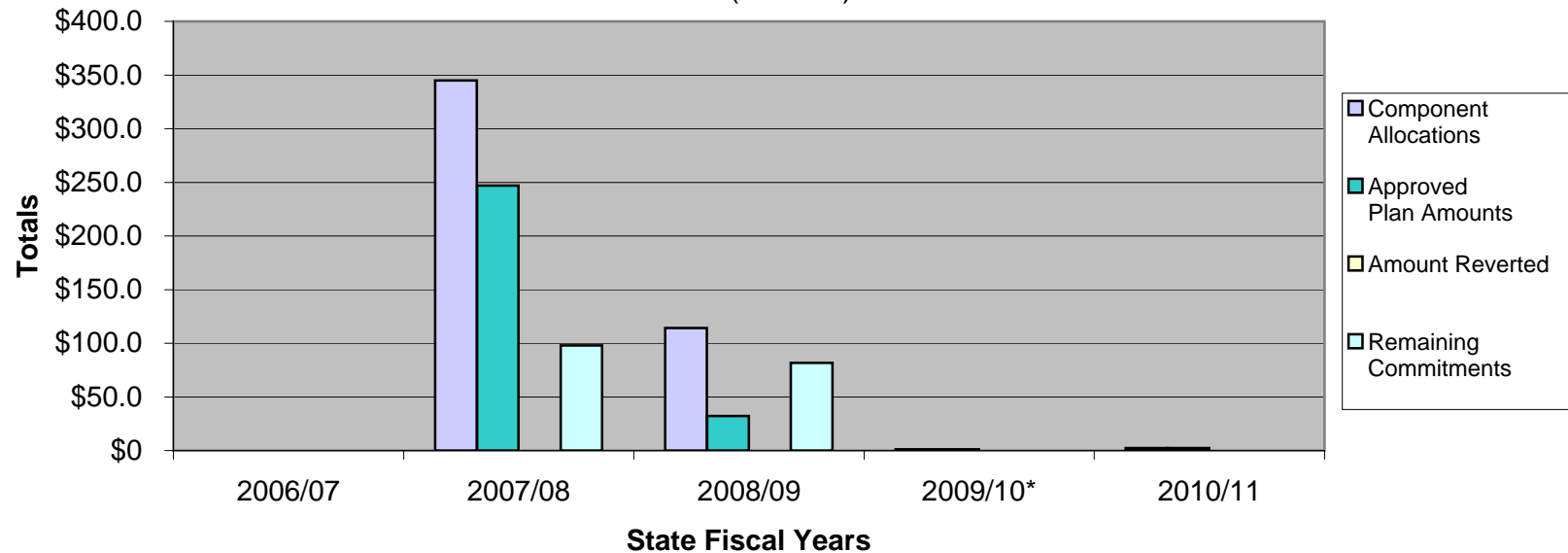


MHSA Funding: County-Level Committed/Distributed/Undistributed/Reverted (By Fiscal Year) 2006/07 through 2010/11				
	Component Allocations	Approved Plan Amounts	Amount Reverted	Remaining Commitments
2006/07	\$ 105.8	\$ 103.0	\$ 0	\$ 2.8
2007/08	\$ 110.0	\$ 104.1	\$ 0	\$ 5.9
2008/09	\$ 9.2	\$ 9.1	\$ 0	\$ 0.1
2009/10	\$ 2.1	\$ 0.1	\$ 0	\$ 2.0
2010/11	\$ 0.1	\$ 0.1	\$ 0	\$ 0
Total	\$ 227.2	\$ 216.4	\$ 0	\$ 10.8

Source: DMH MHSA Summary Comparison (Posted 5/12/2011)

5/26/2011

**MHSA CFTN Funding
Committed/Distributed/Reverted
FY 2006/07 through 2010/11
Ten Year Reversion
(millions)**

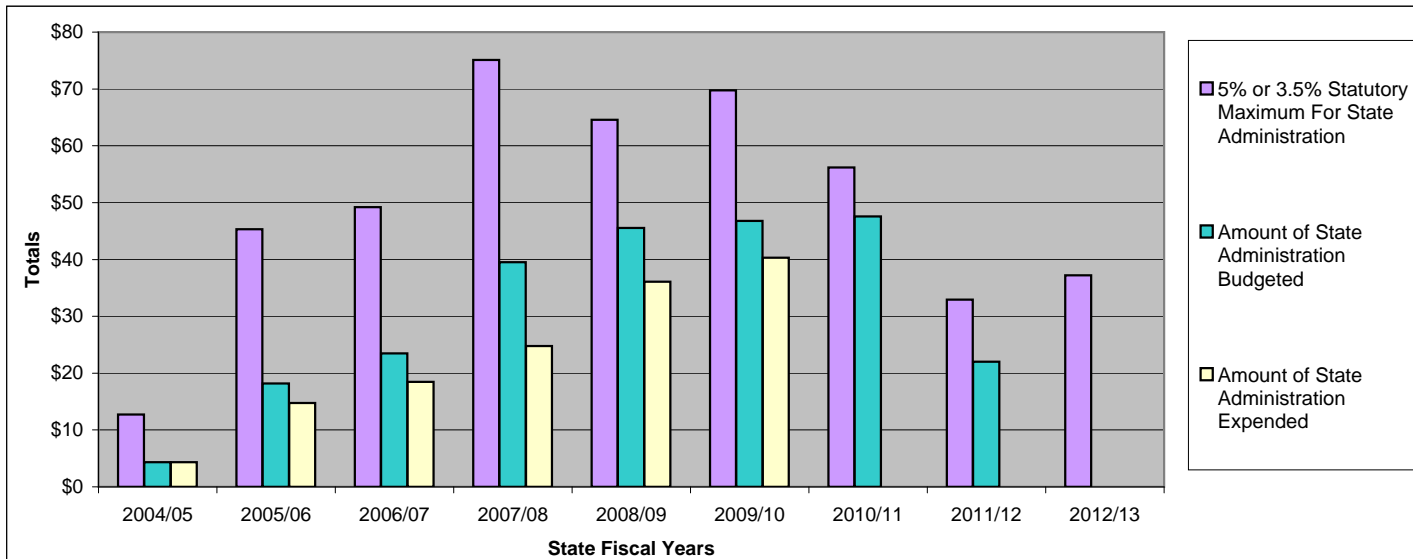


MHSA Funding: County-Level Committed/Distributed/Undistributed/Reverted (By Fiscal Year)				
	Component Allocations	Approved Plan Amounts	Amount Reverted	Remaining Commitments
2006/07	\$ 0	\$ 0	\$ 0	\$ 0
2007/08	\$ 345.0	\$ 247.1	\$ 0	\$ 97.9
2008/09	\$ 114.1	\$ 32.3	\$ 0	\$ 81.8
2009/10	\$ 1.3	\$ 1.2	\$ 0	\$ 0.0
2010/11	\$ 2.3	\$ 2.3	\$ 0	\$ 0
Total	\$ 462.7	\$ 282.9	\$ 0	\$ 179.7

Source: DMH MHSA Summary Comparison (Posted 5/12/2011)

Note: numbers may not match due to rounding

MHSA STATE ADMINISTRATION (Millions)



MHSA: State Administrative Funds				
	5% or 3.5% Statutory Maximum For State Administration	Amount of State Administration Budgeted	Amount of State Administration Expended	
2004/05	\$ 12.7	\$ 4.3	\$	4.3
2005/06	\$ 45.3	\$ 18.2	\$	14.8
2006/07	\$ 49.2	\$ 23.5	\$	18.5
2007/08	\$ 75.1	\$ 39.5	\$	24.8
2008/09	\$ 64.6	\$ 45.6	\$	36.1
2009/10	\$ 69.7	\$ 46.8	\$	40.3
2010/11	\$ 56.2	\$ 47.6		
2011/12	\$ 32.9	\$ 22.0		
2012/13	\$ 37.2			
Total (FY 04/05 -12/13)	\$ 442.9	\$ 247.4	\$	138.7

Unrequested State Administrative funds revert to the MHSF after one year.

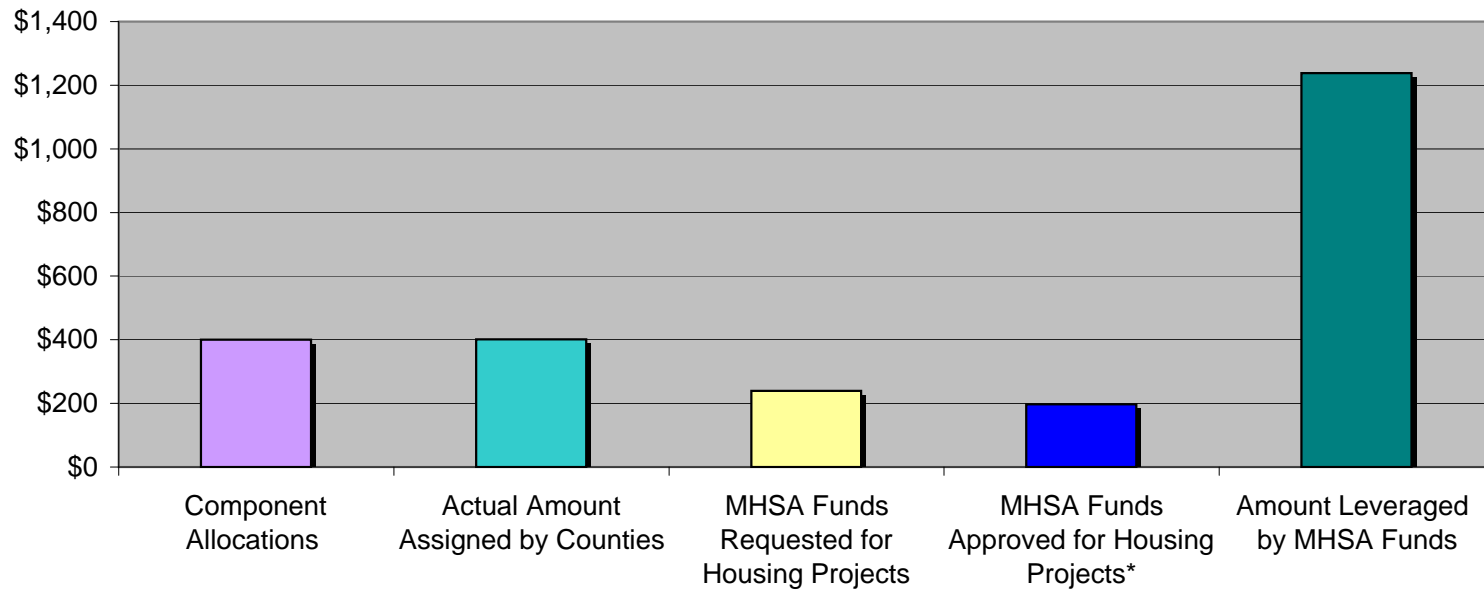
Unexpended State Administrative funds revert to the MHSF after two years.

Effective FY 2011/12, the original 5% statutory maximum for state administration was revised to 3.5% (Assembly Bill 100)

Source: DMH MHSA Expenditure Reports and Proposed Conference Compromise Summary

5/26/2011

MHSA HOUSING PROGRAM (Millions)



MHSA Housing Program				
Component Allocations	Actual Amount Assigned by Counties	MHSA Funds Requested for Housing Projects	MHSA Funds Approved for Housing Projects*	Amount Leveraged by MHSA Funds
\$ 400.0	\$ 401.1	\$ 239.5	\$ 197.2	\$ 1,238.1

Source: DMH MHSA Housing Program Assignment (dated 5/12/11), DMH MHSA Housing Program Application Overview (dated 3/24/11), and MHSA Housing Program Application Status (dated 3/24/11).

*MHSA funds approved as committed loans not as closed loans.

The MHSA Housing program has funded approximately 1,233 MHSA units. A total of 4,428 units have been built to support a wider range of populations.



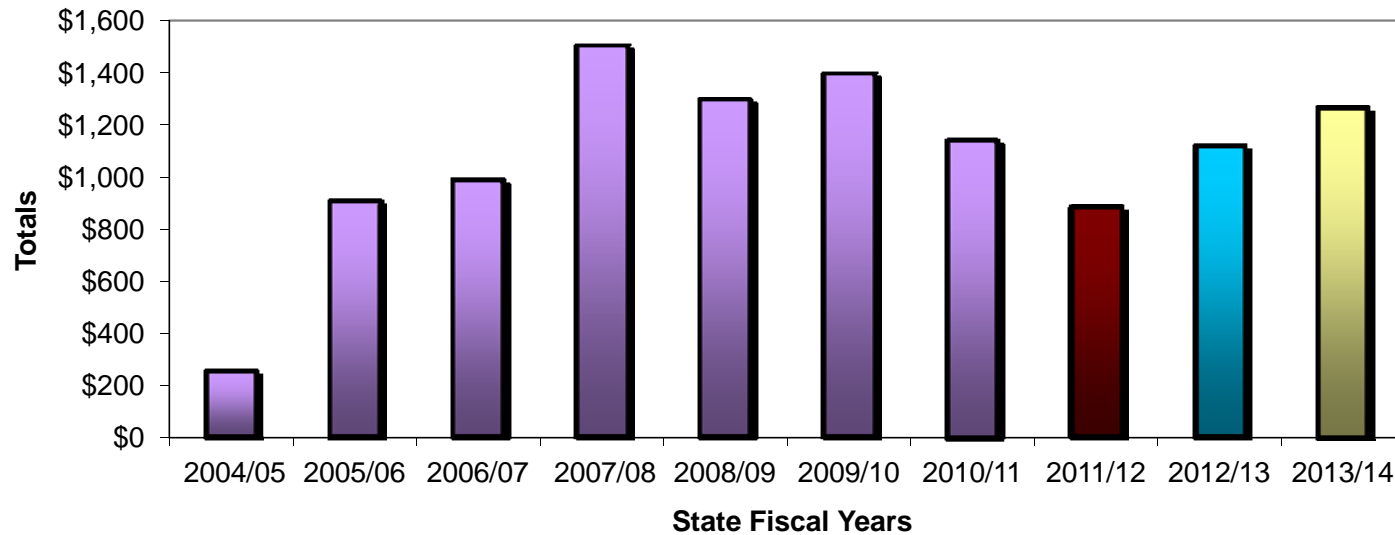
**Mental Health Funding & Policy Committee
Draft Financial Report
January 26, 2012**

1/20/2012

TABLE 1 AND VISUAL 1: MHSA REVENUES RECEIVED

(Millions)

MHSA Revenues Received (Cash Basis) 2004/05 through 2013/14



	SFY 04/05 (actual)	SFY 05/06 (actual)	SFY 06/07 (actual)	SFY 07/08 (actual)	SFY 08/09 (actual)	SFY 09/10 (actual)	SFY 10/11 (actual)	SFY 11/12 (estimated)	SFY 12/13 (projected)	SFY 13/14 (projected)
Cash Transfers	\$169.5	\$894.6	\$935.1	\$983.9	\$797.0	\$799.0	\$905.0	\$945.0	\$1,004.0	\$1,054.7
Adjustment	\$83.6	\$0.0	\$0.0	\$423.7	\$438.0	\$581.0	\$225.0	-\$64.0	\$112.0	\$206.0
Interest Income	\$0.7	\$11.2	\$49.2	\$94.4	\$57.6	\$14.9	\$9.7	\$2.4	\$1.3	\$1.4
TOTAL	\$253.8	\$905.8	\$984.3	\$1,502.0	\$1,292.6	\$1,394.9	\$1,139.7	\$883.4	\$1,117.3	\$1,262.1

A comparison of MHSA revenues on an accrual basis and a cash basis was provided by the California Department of Finance (DOF)

A comparison of MHSA revenues on an accrual basis and a cash basis can be found upon release in the Department of Mental Health's (DMH) MHSA Expenditure Report for FY 2011/12 at http://www.dmh.ca.gov/Prop_63/MHSA/Publications/default.asp

Source: FY 2012/13 Governor's Budget, DOF, DMH MHSA Expenditure Report (FY 04/05 through 11/12 amounts) and the Legislative Analyst Office (LAO) Fiscal Outlook. FY 12/13 and 13/14 cash transfers and interest income are projected amounts based on personal income tax estimates from the LAO. Estimated numbers are for FY 11/12 and projected numbers are for FY 12/13 and 13/14.

Updated 1/20/2012

Updated Semi-Annually

1/20/2012

TABLE 2A: COMMUNITY MENTAL HEALTH FUNDING AMOUNTS
ROLE OF MAJOR FUNDING SOURCES
2003/04 through 2013/14
(Millions)

Actual/Estimated/Projected Totals for the Major Community Mental Health Funding Sources											
	SFY 03/04 (actual)	SFY 04/05 (actual)	SFY 05/06 (actual)	SFY 06/07 (actual)	SFY 07/08 (actual)	SFY 08/09 (actual)	SFY 09/10 (actual)	SFY 10/11 (actual)	SFY 11/12 (estimated)	SFY 12/13 (projected)	SFY 13/14 (projected)
State General Fund (SGF)	\$611.3	\$621.6	653.5	721.8	\$738.5	\$701.0	\$518.0	\$619.4	\$0.1	\$0.0	\$0.0
Realignment	\$1,159.3	\$1,189.9	\$1,217.1	\$1,230.9	\$1,211.5	\$1,072.4	\$1,023.0	\$1,023.0	\$1,104.8	\$1,897.2	\$1,897.2
Federal Financial Participation (FFP)	\$987.5	\$955.5	\$1,019.9	\$1,076.8	\$1,266.4	\$1,404.6	\$1,619.2	\$1,799.9	\$1,562.5	\$1,562.5	\$1,562.5
Proposition 63 Funds (MHSA) Component Allocations*	\$0.0	\$12.7	\$316.9	\$426.3	\$1,488.2	\$1,117.0	\$1,347.0	\$1,165.1	\$1,882.1	\$1,078.2	\$1,217.9
Other	\$255.2	\$276.2	\$295.4	\$306.8	\$313.3	\$233.9	\$187.6	\$139.4	\$139.4	\$150.0	\$150.0
TOTAL	\$3,013.3	\$3,055.9	\$3,502.8	\$3,762.6	\$5,017.9	\$4,528.9	\$4,694.8	\$4,746.8	\$4,689.0	\$ 4,687.9	\$ 4,827.6

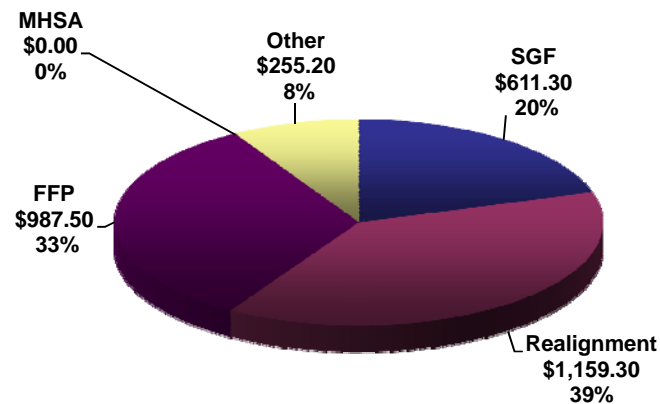
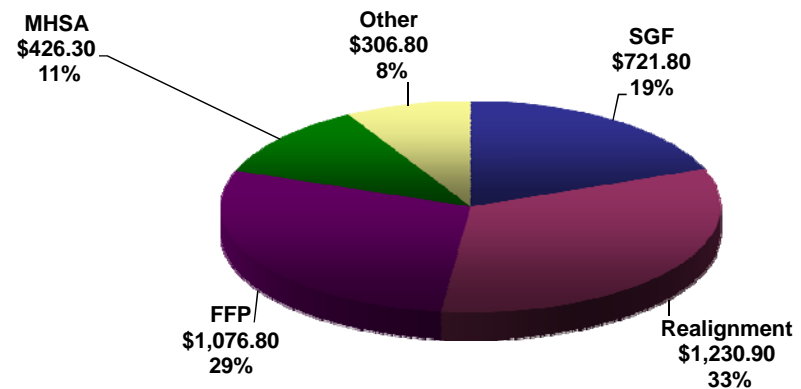
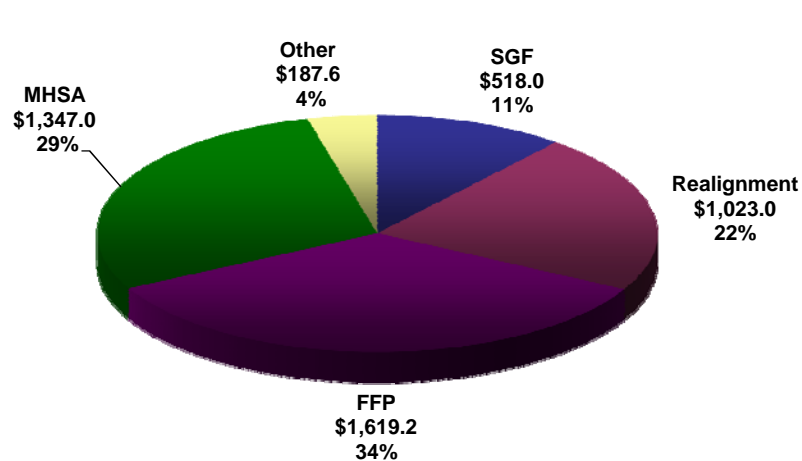
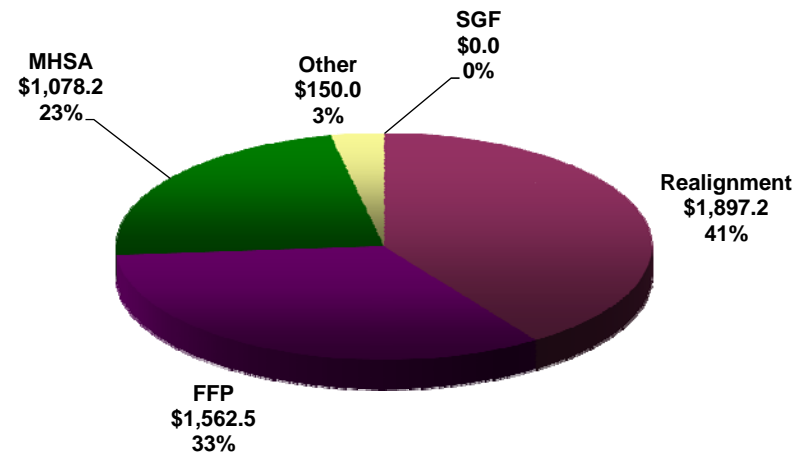
*The figure displayed for Proposition 63 in 2011/12 includes \$1,029.9 million in component allocations and redirected funding for EPSDT and Mental Health Managed Care. Additional funds pursuant to AB 100 are expected to be distributed to counties in addition to component allocations and the one time adjustment of redirected funding in FY 11/12.

Source: FY 2012/13 Governor's Budget, DOF, DMH MHSA Summary Comparison (posted 07/21/2011), MHSOAC Fiscal Consultant Projections ,
and California Department of Health Care Services
See the Index for a description of the primary obligations of each funding source.

Updated 1/20/2012
Updated Annually

VISUAL 2A: COMMUNITY MENTAL HEALTH FUNDING AMOUNTS **ROLE OF MAJOR FUNDING SOURCES**

(Millions)

FY 2003/04: \$3,013.3**FY 2006/07: \$3,762.6****FY 2009/10: \$4,694.8****FY 2012/13: \$4,687.9**

Source: Sources identified in Table 2A

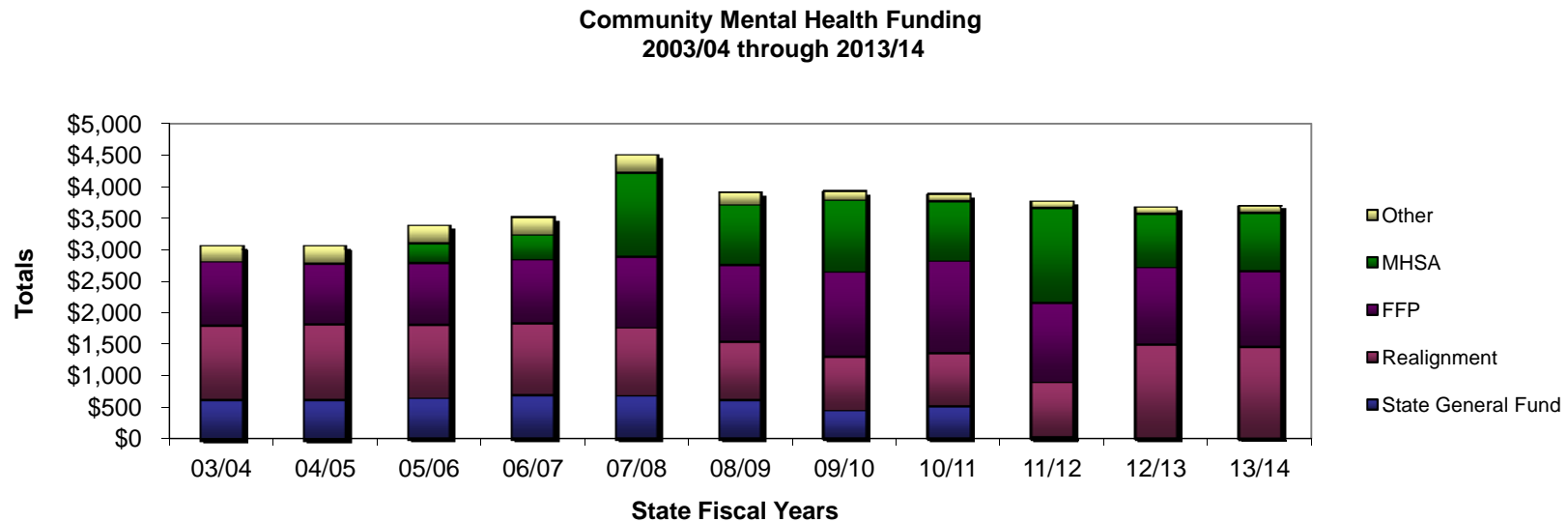
See the Index for a description of the primary obligations of each funding source.

Updated 1/20/2012

Updated Annually

1/20/2012

TABLE 2B AND VISUAL 2B: COMMUNITY MENTAL HEALTH FUNDING
(Millions)



	SFY 03/04 (actual)	SFY 04/05 (actual)	SFY 05/06 (actual)	SFY 06/07 (actual)	SFY 07/08 (actual)	SFY 08/09 (actual)	SFY 09/10 (actual)	SFY 10/11 (actual)	SFY 11/12 (estimated)	SFY 12/13 (projected)	SFY 13/14 (projected)
State General Fund (SGF)	\$611.3	\$621.6	653.5	721.8	\$738.5	\$701.0	\$518.0	\$619.4	\$0.1	\$0.0	\$0.0
Realignment	\$1,159.3	\$1,189.9	\$1,217.1	\$1,230.9	\$1,211.5	\$1,072.4	\$1,023.0	\$1,023.0	\$1,104.8	\$1,897.2	\$1,897.2
Medi-Cal Federal Financial Participation (FFP)	\$987.5	\$955.5	\$1,019.9	\$1,076.8	\$1,266.4	\$1,404.6	\$1,619.2	\$1,799.9	\$1,562.5	\$1,562.5	\$1,562.5
Proposition 63 Funds (MHSA)	\$0.0	\$12.7	\$317.3	\$426.3	\$1,488.2	\$1,117.0	\$1,347.0	\$1,165.1	\$1,882.1	\$1,078.2	\$1,217.9
Other	\$255.2	\$276.2	\$295.4	\$306.8	\$313.3	\$233.9	\$187.6	\$139.4	\$139.4	\$150.0	\$150.0
TOTAL (Without Adjustments)	\$3,013.3	\$3,055.9	\$3,503.2	\$3,762.6	\$5,017.9	\$4,528.9	\$4,694.8	\$4,746.8	\$4,689.0	\$4,687.9	\$4,827.6
Annual % Change in cost of doing business	3.3%	3.2%	3.1%	3%	3.4%	3.4%	2.4%	1.6%	1.9%	2.5%	2.7%
Population (Thousands)	35,276.5	35,624.1	35,896.9	36,073.6	36,251.5	36,493.0	36,742.5	37,008.8	36,875.6	36,942.2	36,908.9
% Change in Population	98.6%	100%	100.8%	100.5%	100.5%	100.7%	100.7%	100.7%	99.6%	100.2%	99.9%
Adjustment	0.986	1	1.038895	1.075332	1.117374	1.1630625	1.1991171	1.2271346	1.24595044	1.2794053	1.3127651
Total Constant Dollars Per Capita	\$3,056.1	\$3,055.9	\$3,372.0	\$3,499.0	\$4,490.8	\$3,894.0	\$3,915.2	\$3,868.2	\$3,763.4	\$3,664.1	\$3,677.4

Source: FY 2012/13 Governor's Budget, DMH MHSA Summary Comparison (Posted 07/21/11), MHSOAC Fiscal Consultant Projections, Department of Finance
Population Report (November 2011), Home Health Agency Market Basket Data

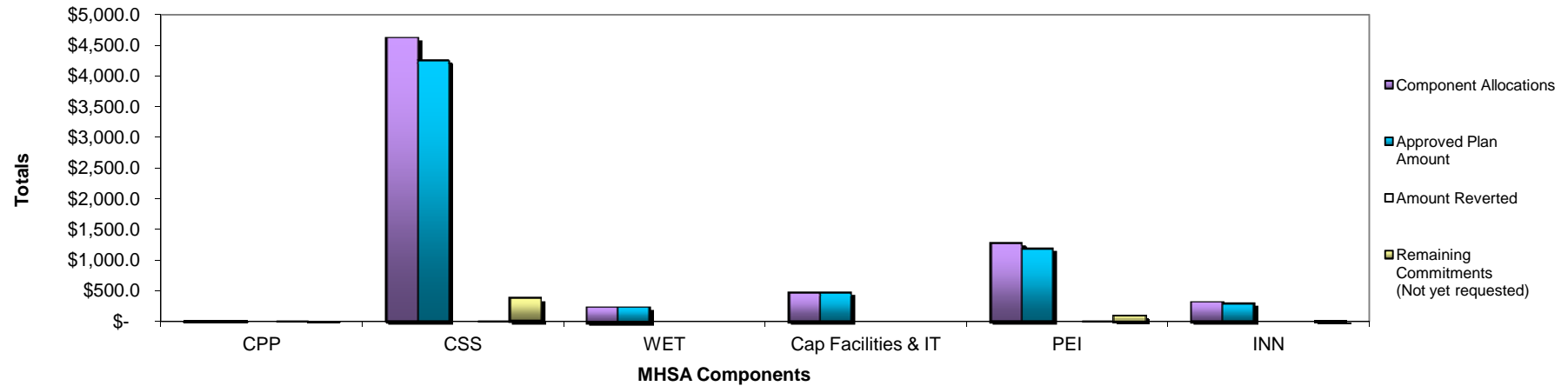
See the Index for a description of the primary obligations of each funding source.

Updated 1/20/2012

Updated Annually

1/20/2012

**TABLE 3 AND VISUAL 3: MHSa Funding
Committed/Distributed/Undistributed/Reverted
2004/05 through 2011/12
(millions)**



MHSa Funding: County-Level Committed/Distributed/Undistributed/Reverted (By Fiscal Year) 2004/05 through 2011/12				
	Component Allocations	Approved/Distributed Funds	Amount Reverted	Remaining Commitments (Not yet requested)
2004/05	\$ 13.0	\$ 12.7	\$ 0.3	0.0
2005/06	\$ 317.3	\$ 315.2	\$ 2.1	0.0
2006/07	\$ 426.3	\$ 426.3	-	-
2007/08	\$ 1,488.1	\$ 1,487.9	\$ 0.2	-
2008/09	\$ 1,117.0	\$ 1,117.0	-	-
2009/10	\$ 1,347.0	\$ 1,347.0	-	-
2010/11	\$ 1,165.4	\$ 1,165.4	-	-
2011/12*	\$ 1,029.9	\$ 542.5	-	\$ 487.5
Total (FY 04/05 - 11/12)	\$ 6,904.0	\$ 6,414.0	\$ 2.6	\$ 487.5

Source: DMH MHSa Summary Comparison (Posted 07/21/11)

* Upon enactment of AB 100, effective March 24, 2011, State plan approval was no longer required to receive funds.

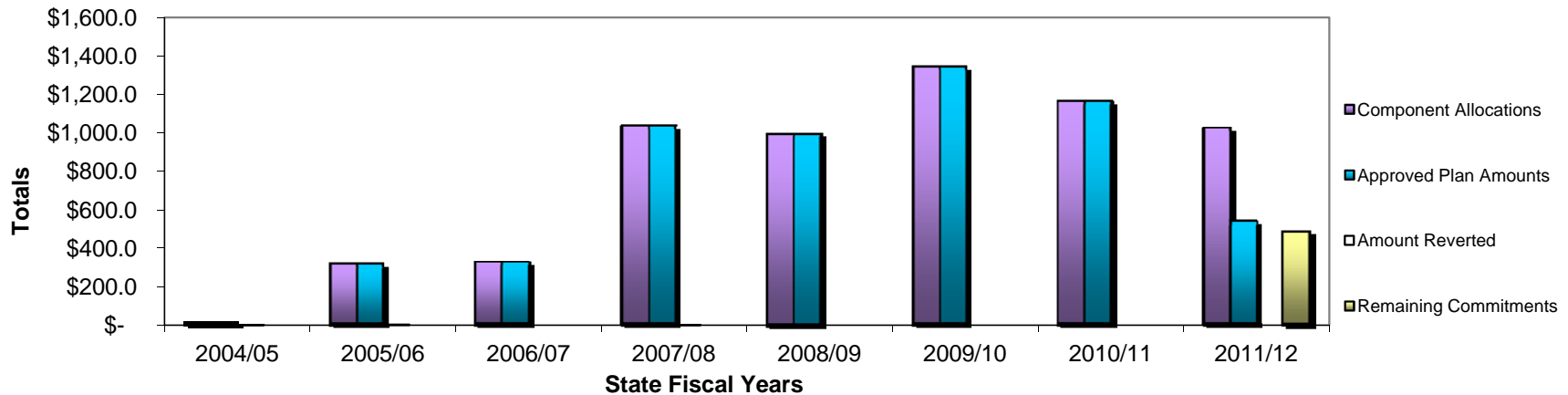
The amount shown for 2011/12 (\$542.5) was reported on 07/21/2011. At this time, no further information is available. The remaining component allocations will be distributed no later than April 30, 2012.

Updated 1/20/2012

Updated Semi-Annually

1/20/2012

**MHSA Funding: Combined CSS, PEI and INN
Committed/Distributed/Undistributed/Reverted
2004/05 through 2011/12
Three Year Reversion
(millions)**



MHSA Funding: County-Level Committed/Distributed/Undistributed/Reverted (By Fiscal Year) 2004/05 through 2011/12				
	Component Allocations	Approved/Distributed Funds	Amount Reverted	Remaining Commitments
2004/05	\$ 13.0	\$ 12.7	\$ 0.3	0.0
2005/06	\$ 317.3	\$ 315.2	\$ 2.1	0.0
2006/07	\$ 320.5	\$ 320.5	-	-
2007/08*	\$ 1,033.2	\$ 1,033.0	\$ 0.2	-
2008/09**	\$ 993.7	\$ 993.7	-	-
2009/10	\$ 1,343.6	\$ 1,343.6	-	-
2010/11	\$ 1,163.0	\$ 1,163.0	-	-
2011/12***	\$ 1,020.9	\$ 533.5	-	\$ 487.4
Total	\$ 6,205.1	\$ 5,715.2	\$ 2.6	\$ 487.4

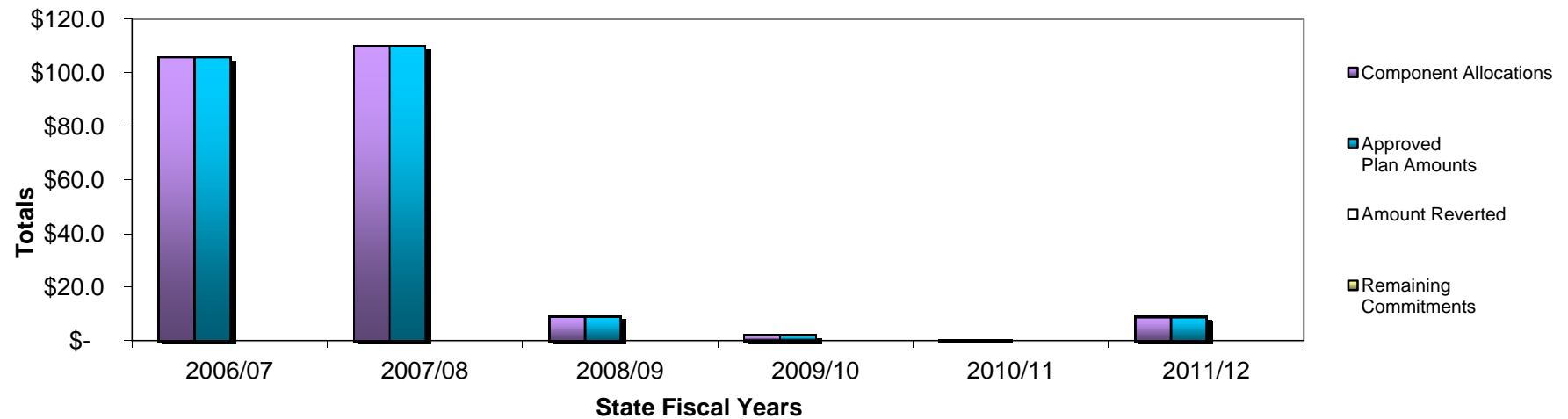
*Remaining commitments in 2007/08 are subject to reversion on 07/01/10.

**Remaining commitments in 2008/09 are subject to reversion on 07/01/11.

*** Upon enactment of AB 100, effective March 24, 2011, State plan approval was no longer required to receive funds. The amount shown for 2011/12 (\$533.5) was reported on 07/21/2011. At this time, no further information is available. The remaining component allocations will be distributed no later than April 30, 2012.

1/20/2012

**MHSA WET Funding
Committed/Distributed/Reverted
2006/07 through 2011/12
Ten Year Reversion
(millions)**

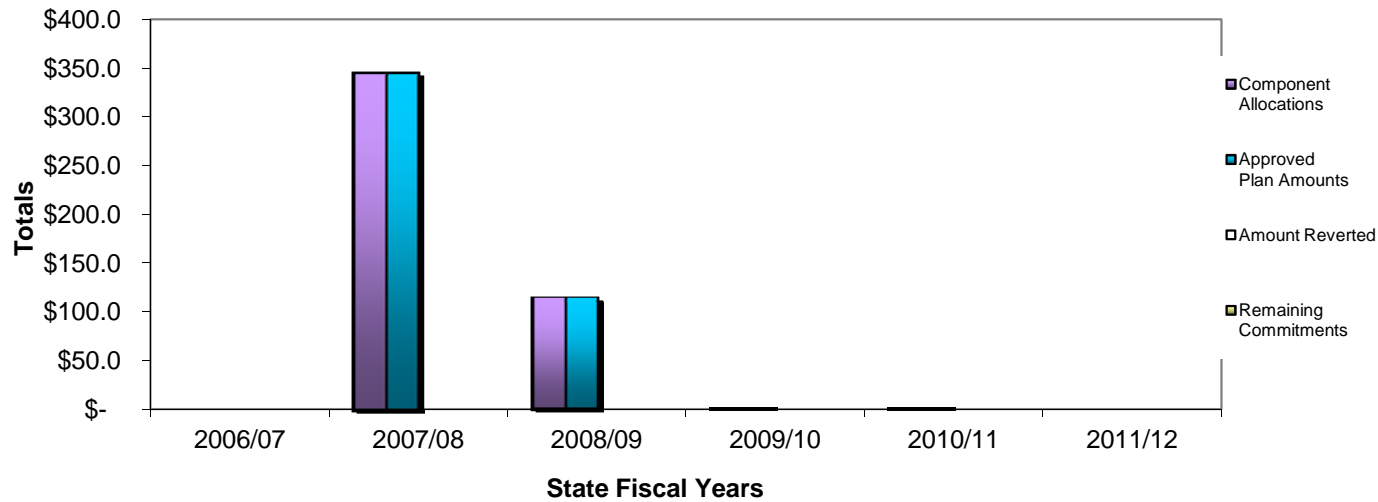


MHSA Funding: County-Level Committed/Distributed/Undistributed/Reverted (By Fiscal Year) 2006/07 through 2009/10				
	Planning Estimates	Approved/Distributed Funds	Amount Reverted	Remaining Commitments
2006/07	\$ 105.8	\$ 105.8	\$ -	\$ -
2007/08	\$ 110.0	\$ 110.0	\$ -	\$ -
2008/09	\$ 9.2	\$ 9.2	\$ -	\$ -
2009/10	\$ 2.1	\$ 2.1	\$ -	\$ -
2010/11	\$ 0.1	\$ 0.1	\$ -	\$ -
2011/12*	\$ 9.0	\$ 9.0	\$ -	\$ -
Total	\$ 236.2	\$ 236.2	\$ -	\$ -

* Upon enactment of AB 100, effective March 24, 2011, State plan approval was no longer required to receive funds.

1/20/2012

**MHSA CFTN Funding
Committed/Distributed/Reverted
2006/07 through 2011/12
Ten Year Reversion
(millions)**



MHSA Funding: County-Level Committed/Distributed/Undistributed/Reverted (By Fiscal Year) 2006/07 through 2011/12				
	Planning Estimates	Approved/Distributed Funds	Amount Reverted	Remaining Commitments
2006/07	\$ -	\$ -	\$ -	\$ -
2007/08	\$ 345.0	\$ 345.0	\$ -	\$ -
2008/09	\$ 114.1	\$ 114.1	\$ -	\$ -
2009/10	\$ 1.3	\$ 1.3	\$ -	\$ -
2010/11	\$ 0.3	\$ 0.3	\$ -	\$ -
2011/12*	\$ -	\$ -	\$ -	\$ -
Total	\$ 460.7	\$ 460.7	\$ -	\$ -

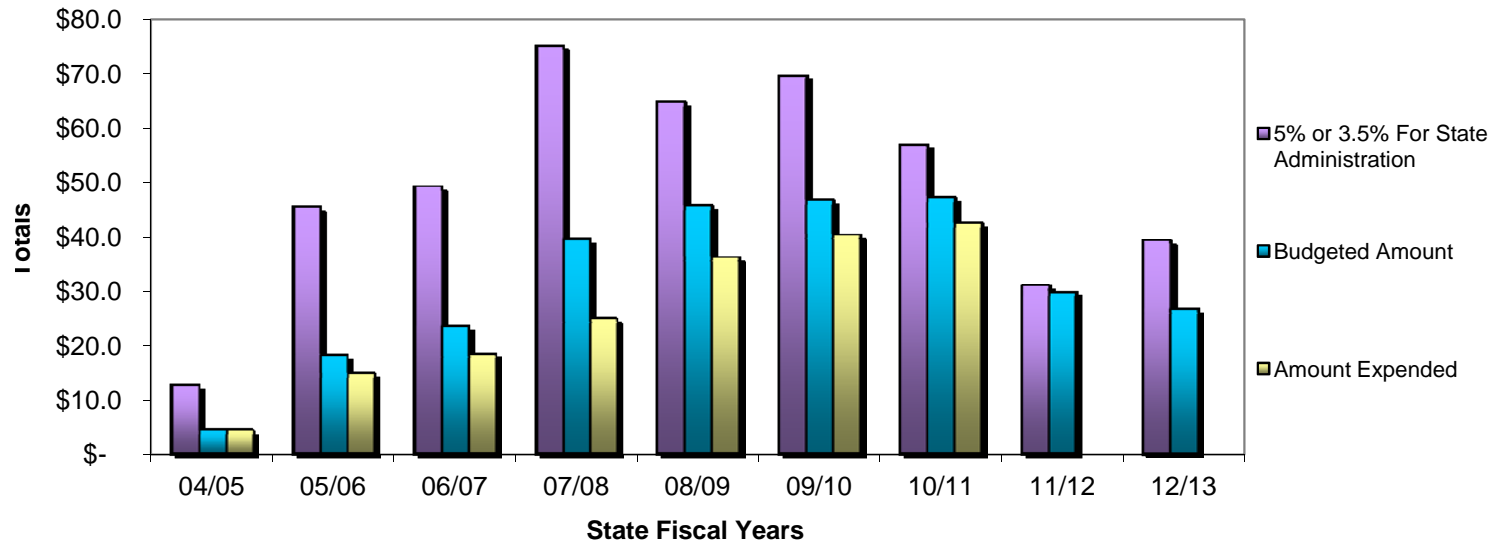
Ten percent of the CSS funds from FY 2005/06-2007/08 went to CFTN and WET. Beginning in FY 2008/09, there are not specific allocations for CFTN or WET. Counties may take money from CSS and put funds into CFTN, WET or Prudent Reserve (the maximum shall not exceed 20 percent of the average for the prior 5 years).

*The CFTN Committed/Distributed/Reverted financial information is not available for FY 2011/12 at this time.

Source: DMH MHSA Summary Comparison (Posted 07/21/2011)

1/20/2012

TABLE 6 AND VISUAL 6: MHSA STATE ADMINISTRATION
(Millions)



MHSA: State Administrative Funds				
	5 % or 3.5% Statutory Maximum For State Administration	Amount of State Administration Budgeted	Amount of State Administration Expended	
2004/05	\$ 12.7	\$ 4.3	\$	4.3
2005/06	\$ 45.3	\$ 18.2	\$	14.8
2006/07	\$ 49.2	\$ 23.5	\$	18.5
2007/08	\$ 75.1	\$ 39.5	\$	24.8
2008/09	\$ 64.6	\$ 45.6	\$	36.1
2009/10	\$ 69.7	\$ 46.8	\$	40.3
2010/11	\$ 57.0	\$ 47.2	\$	42.5
2011/12	\$ 30.9	\$ 29.7	\$	-
2012/13	\$ 39.1	\$ 26.4	\$	-
Total (All Years)	\$ 443.7	\$ 281.2	\$	181.2

Unrequested State Administrative funds revert to the MHSF after one year.

Unexpended State Administrative funds revert to the MHSF after two years.

Effective FY 2011/12 the original 5% statutory maximum for state administration was revised to 3.5% (Assembly Bill 100)

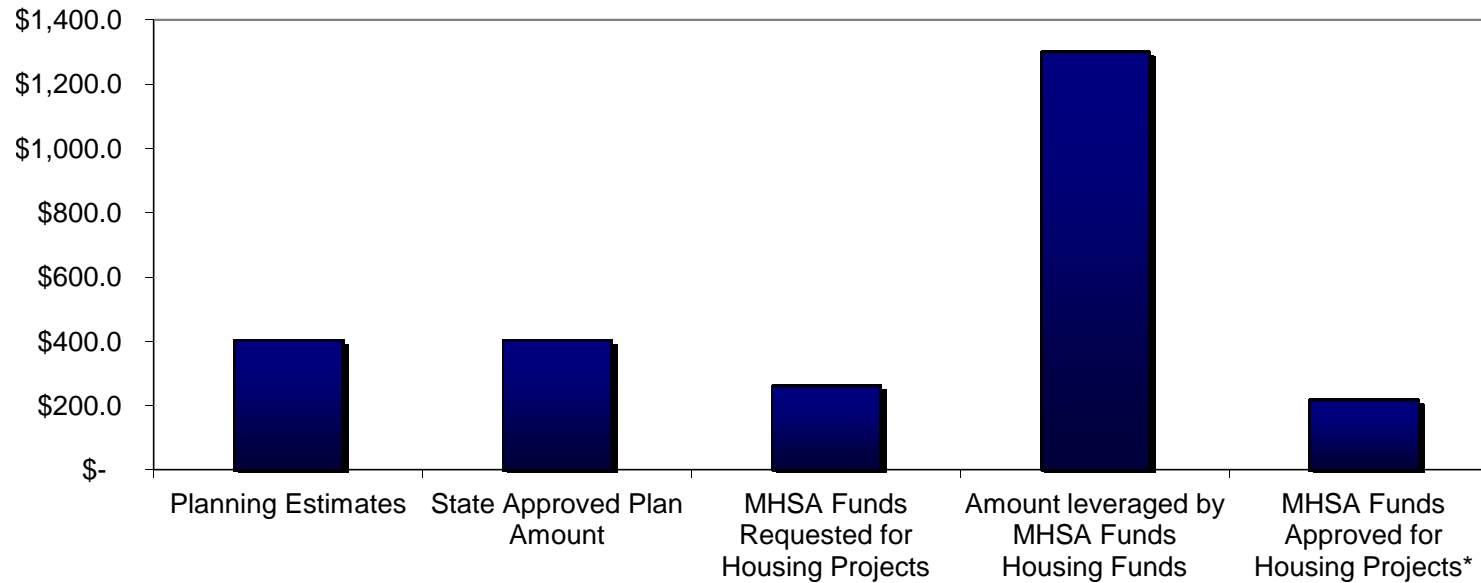
Source: DMH MHSA Expenditure Reports and Fund Condition Statements

Updated 1/20/2012

Updated Semi-Annually

1/20/2012

TABLE 9 AND VISUAL 9: MHSA HOUSING PROGRAM
(Millions)



MHSA Housing Program				
Planning Estimates	State Approved Plan Amount	MHSA Funds Requested for Housing Projects	Amount leveraged by MHSA Funds Housing Funds	MHSA Funds Approved for Housing Projects*
\$ 404.1	\$ 404.1	\$ 261.7	\$ 1,300.0	\$ 216.2

Source: DMH MHSA Housing Program Application Overview (dated 10/10/11)

*MHSA funds approved as committed loans not as closed loans.

The MHSA Housing program has funded (loan commitments) of approximately 1,332 MHSA units. A total of 4,819 units have been built to support a wider range of populations.

Updated 1/20/2012
Updated Semi-Annually

FINANCIAL REPORT INDEX

TABLES 2A-B & VISUAL 2A-B

State General Fund (SGF): The SGF is funded through personal income tax, sales and use tax, corporation tax, and other revenue and transfers. Prior to the Governor's FY 2011/12 Budget Proposal, the primary obligations of the SGF provided to counties for mental health are to fund specialty mental health benefits of entitlement programs including Medi-Cal Managed Care, Early and Periodic Screening Diagnosis Treatment (EPSDT) and Mental Health Services to Special Education Pupils (AB 3632).

Realignment: Realignment is the shift of funding and responsibility from the State to the counties to provide mental health services, social services and public health. There are two sources of revenue that fund realignment; 1/2 cent of State sales taxes and a portion of State vehicle license fees. The primary mental health obligation of realignment is to provide services to individuals who are a danger to self/others or unable to provide for immediate needs. It is also a primary funding source for community-based mental

long-term care services. 2011 Realignment gives counties the funding responsibility for EPSDT and Mental Health Managed Care. health services, State Hospital services for civil commitments and institutions for Mental Disease (IMDs) which provide

Federal Financial Participation (FFP): FFP is the federal reimbursement counties receive for providing specialty mental health treatment and Healthy Families Program beneficiaries. The amount of federal reimbursement received by counties is based on a percentage established for California called the Federal Medical Assistance Percentage (FMAP).

Proposition 63 Funds (MHSA): The MHSA is funded by a 1% tax on personal income in excess of \$1 million. The primary obligations of the MHSA is for counties to expand recovery based mental health services, to provide prevention and early intervention services, innovative programs, to educate, train and retain mental health professionals, etc.

Other: Other revenue comes from a variety of sources--county funds are from local property taxes, patient fees and insurance, grants, etc. The primary obligation of the county funds is the maintenance of effort (the amount of services required to be provided by counties in order to receive realignment funds).

TABLE 6 & VISUAL 6

The State Administration has up to 5% of the MHSF available. In order to have access to funds, within the 5%, the State Administration must request these funds through the State budget process. Upon approval, the requested amount is then budgeted in the requesting department's approved budget. The funds that are unrequested for a specific FY (within the 5%) revert back to the MHSF after one year. Once the funds are budgeted then the departments can expend these funds. The unexpended budgeted amounts will revert back to the MHSF after two years. Beginning FY 11/12, the State Administration maximum is up to 3.5%.